**CARPAL TUNNEL SYNDROME**

**PRIOR APPROVAL FORM**

**Please ensure all sections are completed and any requested supporting information is provided to ensure a prompt decision. Unless the patient fully meets the criteria, funding will not be approved unless there are exceptional reasons.**

**PART A – MUST BE COMPLETED FOR ALL REQUESTS**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **GP/CONSULTANT DETAILS** | | | | | | |
| Name: | |  | | GP Practice Code: | |  |
| Address: | |  | | Trust: | |  |
| Preferred Contact (Email) - Only NHS.NET addresses are acceptable: | | @nhs.net | | | | |
| **PATIENT’S DETAILS** | | | | | | |
| NHS No: |  | | MRN (if applicable): | |  | |
| Date of Birth: |  | | | | | |

**Requesting clinician – please confirm the following.**

|  |  |  |
| --- | --- | --- |
| Patient Consent: The Patient hereby gives consent for disclosure of information relevant to their case from professionals involved and to the ICB. | Yes | No |
| I have informed the patient that this intervention will only be funded where the criteria are met. | Yes | No |
| I confirm that I have reviewed the patient against the commissioning criteria and that the information provided within this application is accurate. | Yes | No |

**PART B – MUST BE COMPLETED FOR ALL REQUESTS**

|  |  |  |
| --- | --- | --- |
| **ACCESS CRITERIA** | | |
| **Please provide further information as relevant** | | |
| The symptoms significantly interfere with daily activities and sleep symptoms and have not settled to a manageable level with either one local corticosteroid injection and/or nocturnal splinting for a minimum of 8 weeks. **(Details of the impact on daily activities to be included in the prior approval application - see note)** | Yes | No |
| **OR**  There is either (i) a permanent (ever-present) reduction in sensation in the median nerve distribution; or (ii) muscle wasting or weakness or thenar abduction (moving the thumb away from the hand). | Yes | No |

***Note: Significant functional impairment of daily activities is defined by the ICB as:***

* + ***Symptoms prevent the patient fulfilling vital work or educational responsibilities.***
  + ***Symptoms prevent the patient carrying out vital domestic or carer activities.***

**Please provide evidence below to support the information provided. Without evidence your application may be rejected. If you prefer you can attach supporting information, such as a clinic letter, rather than completing the box below.**

|  |
| --- |
| Supporting information: |

How to complete:

* Add GP/Consultant details.
* Add Patient details.
* Tick to answer yes or no to criteria listed under the procedure being requested.
* Provide supporting information to evidence assessment in the free text area or attach supporting information such as clinic letter.
* Email form to [glicb.ifr@nhs.net](mailto:glicb.ifr@nhs.net)
* Response will be sent from Gloucestershire ICB to the preferred contact for reply within a maximum of 10 working days.
* Please complete the form in typeface.

May 2025