

**NHS Mansfield and Ashfield Clinical Commissioning Group**

*On behalf of NHS Mansfield & Ashfield, NHS Newark & Sherwood, NHS Nottingham North & East,*

 *NHS Nottingham West and NHS Rushcliffe Clinical Commissioning Groups*

**Orthotic Functional Electrical Stimulation (FES) for ‘foot drop’ of neurological origin**

**PRIOR APPROVAL FORM September 2013**

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| 1. **Patient and request details**
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| Date of request |  |
| Patient NHS number, initials and date of birth |  |
| Patient GP practice address and CCG |  |
| Specialist who has made referral [name, job title, organisation] |  |
| Proposed service provider |  |
| Prior approval form completed by [name, job title, organisation]*Please note: Completion should be by a specialist clinician who knows and has assessed this patient, or be based on documentary evidence of such assessments, sufficient to complete the form.* |

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| 1. **Pre-screening prior to Assessment for FES**
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| **Patient meets policy criteria outlined in the commissioning policy for the use of FES including the following (please tick relevant boxes and provide detail where indicated):** |

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| Clinical indication for FES (Please state) |
|  | **Yes** | **No** |
| Has the patient been assessed by a specialist in foot drop of neurological origin?Have a range of treatment options been considered?A referral letter must be submitted with this form. Referral or clinic letter attached? | 🞏🞎🞎 | 🞏🞎🞎 |
| What alternatives have been considered and/or tried? Please provide details (including outcomes): |  |  |
| Can the patient walk more than or equal to 10 metres independently (+/- walking aids)? | 🞎 | 🞎 |
| Has the patient reported any trips or falls or do they have gait problems related to foot drop? If yes please provide details: | 🞎 | 🞎 |
| Can the patient physically manage a FES (+/- minimal assistance)? | 🞎 | 🞎 |
| Is the patient’s cognitive ability such that they can manage a FES independently?  | 🞎 | 🞎 |
| Are the FES treatment goals and expectations of benefit clear?Please provide details of these: | 🞎 | 🞎 |
| Does the patient have any co morbidities which may affect their capacity to benefit from FES? If yes please provide details: | 🞎 | 🞎 |
| **Does the patient have any of the following:** | **Yes** | **No** |
| Fixed contractures of the joint associated with muscles to be stimulated? | 🞎 | 🞎 |
| Broken or poor condition of skin? | 🞎 | 🞎 |
| Inability to stimulate site? | 🞎 | 🞎 |
| Acute concurrent DVT? | 🞎 | 🞎 |
| Receptive dysphasia?  | 🞎 | 🞎 |
| Complete peripheral nerve damage? | 🞎 | 🞎 |
| Pacemaker in situ? | 🞎 | 🞎 |
| Life expectancy <12 months? | 🞎 | 🞎 |
| Any other accepted contraindications to FES e.g. pregnancy, uncontrolled epilepsy etc? | 🞎 | 🞎 |
| If yes to any of the above, please provide details: |  |  |
|  |  |  |
| Patient’s baseline clinical condition, including:* Predominant symptoms and measures of effort, walking speed, gait, trips and falls etc
* SF36 or EQ-5D assessment
* Co-morbidities
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**Approval for FES will be granted on condition that**

* The patient meets the criteria outlined in the policy
* The patient has agreed to proceed with the treatment
* The clinical team provides the clinical information requested below as required
* **Approval for FES** **Yes** 🞎  **No** 🞎 **Date**………………………………

**Approved on behalf of** ………………………………**CCG by**……………………............

Completed form including referral and/or clinic letters to be sent to;

Individual Funding Request Team

NHS Mansfield and Ashfield CCG

Hawthorn House

Ransom Wood Business Park

Southwell Road West

Rainworth

Mansfield

Nottingham

NG21 0HJ

Safe Haven Fax; 01623 673352

Email: Maccg.ifrteam-nottscountyccgs@nhs.net

**PLEASE NOTE THAT A PROGRESS REPORT WILL BE REQUESTED ONE YEAR AFTER TREATMENT. FAILURE TO PROVIDE THIS INFORMATION MAY INFLUENCE THE FUNDING OF FUTURE CASES.**