

**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):** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 |  | | |

**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](mailto: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.**