**EXCEPTIONAL REFERRALS PANEL APPLICATION FORM**

**This form is to be completed by the referring clinician in discussion with the patient.**

**PLEASE NOTE: Only the information detailed on this form will be used to inform the panel’s decision, Please ensure that you provide sufficient information for the panel to be able to come to an informed decision. Any requests for treatment outwith Scotland, please complete appendix 1.**

**It is strongly recommended that this form is completed and transferred electronically to** **dg.ERP@nhs.scot**

|  |  |  |
| --- | --- | --- |
| **PATIENT CHI NUMBER or DATE OF BIRTH:** | **PATIENT POSTCODE :** | **DATE OF REFERRAL :** |
| **Clinical Urgency (please tick):** **Routine (response required within 2-4 weeks)** **Urgent (response required within 1 week)**  |
| **REFERRING CLINICIAN****Name (Clinician): Speciality:****Address:****Tel: E-mail:**  |
| **Directorate Associate Medical Director Support:**I confirm that I have discussed this request with the appropriate \*Directorate Associate Medical Director (AMD) who has supported this.  **[ ]** Tick here to confirm. |
| **SUMMARY OF RELEVANT CLINICAL INFORMATION**Patient’s current medical condition:History, including any care or treatment the patient has already received for this condition: |
| **EXCEPTIONAL TREATMENT** Exceptional assessment, care or treatment requested:Proposed provider of this service - If the provider of this treatment is **outwith Scotland** please go straight to **Appendix 1** at the end of this form for completion:Cost of this care / treatment if known: |
| **ALTERNATIVES**To your knowledge what alternatives, if any, to the exceptional care / treatment requested are available locally or under the Health Board’s existing service level agreements?Have any of these alternatives been tried or considered? If not please give reasons: |
|  **Please give details of any evidence of effectiveness you are aware of for the exceptional care / treatment requested:** |
| **What impact / benefits would you expect for the patient over what timescale?** |
| **Please describe any further ‘exceptional’ circumstances you consider relevant to this case:** |

**PLEASE RETURN THE COMPLETED FORM VIA EMAIL TO:**

**The Exceptional Referral Panel - Email:** **dg.ERP@nhs.scot**

**To be completed by Chair of Exceptional Referral Panel.**

|  |  |
| --- | --- |
| **Panel Chair** |  |
| **Approved**  | **Yes/No** |
| **Conditions of Approval** |  |
| **Reasons for Non-Approval** |  |
| **Appeal:****If you wish to appeal a decision you should write to Dr Kenneth Donaldson via email** **dg.medicaldirector@nhs.scot** **Within 2 months of the date below.** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **By ticking this box I confirm that I am the ERP Chair as detailed above:**  | **[ ]**  | Date: |  |

**\*Associate Medical Directors**

**Acute & Diagnostics: Andrew Russell (****andrew.russell6@nhs.scot****)**

**Mental Health: Esther Mackenzie (esther.mackenzie@nhs.scot)**

**Primary Care: Grecy Bell (****grecy.bell2@nhs.scot****)**

**Women & Children: Ben Rayen (****ben.rayen@nhs.scot****)**

**Appendix 1.**

**Funding Application for Specialist Healthcare not available in Scotland.**

|  |  |
| --- | --- |
| **Patient Identifier**(Patient Initials, DOB & First Half of Postcode) |  |
| **NHS Board of Residence** | [Select from drop-down list] |
| **Date Approved by NHS Board of Residence for submission to NSD**  |  |
| **Clinical Category** Select category which best reflects intervention being sought. | [Select from drop-down list]  |
| **Specialist Treatment/Service Required** Please include details of diagnosis including a brief description of the condition requiring specialist input/intervention. |  |
| **Specialist Components Required**Select all elements this funding request applies to. | **[ ]** Clinical Assessment **[ ]**  Management Advice **[ ]** Diagnostic Test**[ ]**  Clinical Intervention **[ ]**  First Follow-up Appointment  (Any long-term follow-up is the responsibility of the NHS Board of residence) |
| **Reason(s) for Referral**Please provide a summary of why a referral is necessary to a Healthcare Provider outside of Scotland including reference to any clinical discussion within an MDT. |  |
| **Healthcare Provider** Please provide details of the Consultant / Hospital / NHS Trust the patient is being referred to. |  |
| **Indicative Costs / Length of Treatment** Please provide an indication of the costs of the treatment / intervention.  |  |
| **Advise of any other treatment options available within the NHS in Scotland** |  |
| **Details of Referring Clinician**Please include:* Name & Designation
* Email address
* Service/Department
* Hospital
 |  |

**DECLARATION -** **Please confirm that you agree and accept the following statements**:

**[ ]**  I confirm that the specialist intervention requested is not available within the NHS in Scotland.

**[ ]**  I confirm the patient is aware of the need to travel for treatment.

**[ ]**  As the local referrer, I will remain responsible for the patient’s ongoing care needs which would not be met by the specific provision of the healthcare provider.

**[ ]**  Any ongoing follow-up costs will remain the responsibility of the patient’s NHS Board where the patient cannot be repatriated back to Scotland.