**INFORMATION TO ACCOMPANY AN INDIVIDUAL FUNDING REQUEST (IFR) FOR**

**TREATMENT FOR VARICOSE VEINS**

### PATIENT DETAILS

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME** |  | | |
| **DATE OF BIRTH** |  | **NHS NUMBER** |  |
| **ADDRESS** |  | | |
| **REFERRING GP (please print name and stamp practice address)** |  | | |
| **BMI (taken within the last 6 months)** |  | | |

|  |  |  |
| --- | --- | --- |
| Have first line treatments been tried for at least six months (advice on walking and exercise, avoidance of activities that exacerbate symptoms, leg elevation, occupational factors, weight loss etc.)? | YES | NO |

### ADDITIONAL INFORMATION

### \*\*Failure to complete this questionnaire in full may delay the IFR Panel’s decision\*\*

The interventional treatment of varicose veins will only be commissioned where one or more of the following clinical criteria are met and the BMI is below 30:

**Please tick all the boxes that apply to your patient**

|  |  |
| --- | --- |
| Significant skin changes such as varicose eczema or lipodermatosclerosis with oedema secondary to chronic venous insufficiency. |  |
| At least two episodes of documented superficial thrombophlebitis associated with sever and persistent pain, requiring analgesia and affecting activities of daily living. |  |
| Intractable ulceration secondary to venous stasis. |  |
| Previous episode of bleeding from the varicosity i.e. more than one episode of minor haemorrhage or one episode of significant haemorrhage. |  |
| Symptomatic varicose veins i.e. severe symptoms which cannot be attributed to any other cause and affecting activities of daily living that would be reversed or significantly improved by treatment. |  |

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| Please provide any other relevant information in support of your request: |

GP Signature ………………………………………… Date ………………………………..