Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund haemorrhoidectomy when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	**Delete as appropriate**	
Recurrent third or fourth degree combined external/internal haemorrhoids with persistent pain or bleeding **OR**	Yes	No
Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR**	Yes	No
Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct-current electrotherapy.)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the CCG's Individual Funding Request policy for further information.*