**INFORMATION TO ACCOMPANY REQUEST FOR ABDOMINOPLASTY**

**The NHS does not routinely commission plastic surgery for cosmetic reasons, an NHS referral is inappropriate if the patient falls within the normal morphological range.**

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

### PATIENT IDENTIFICATION DETAILS

|  |  |
| --- | --- |
| PATIENT’S NAME: | **<Patient Name>** |
| DATE OF BIRTH: | **<Date of birth>** | NHS NUMBER: | **<NHS number>** |
| ADDRESS: | **<Patient Address>** |
| REFERRING GP: | **<Sender Name>, <Organisation Address>, <GP Details>** |

In your clinical opinion is the patient currently experiencing severe difficulties with daily living i.e. ambulatory/ urological restrictions [ ]  YES [ ] NO

|  |
| --- |
| If YES please give details:       |

Please specify any patient weight loss that has contributed to the perceived requirement for abdominoplasty:

|  |  |
| --- | --- |
| Initial Weight (KG) |       |
| Date (MM/YY) |       |

|  |  |
| --- | --- |
| Current Weight (KG) | <Latest Weight> |
| Date (MM/YY) | <Today's date> |

|  |  |
| --- | --- |
| Total weight loss to date |       |
| Height | <Latest Height> |
| Current BMI | <Latest BMI> |

Has the patient undergone weight loss surgery? [ ]  YES [ ]  NO DATE OF SURGERY:

Was the weight loss surgery performed by the NHS? [ ]  YES [ ]  NO

Length of time current weight loss has been stable:

Does the patient suffer from any other relevant physical problems (e.g. persistent intertrigo)

|  |
| --- |
| Details:       |

**GP Signature:** <Sender Name>  **Date:** <Today's date>

Please send to: **Individual Funding Request (IFR) Business Support**

**722 Prince of Wales Road, S9 4EU**

**or FAX to 0114 305 1370 (safe haven fax)**

**or EMAIL to** sheccg.sybifr@nhs.net **(safe haven email)**