

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

Please send this form with the referral letter.

Hallux Valgus Surgery

Instructions for use:

Please refer to policy for full details.

Primary Care clinicians need to complete the checklist and submit with referral via eRS /
 Secondary Care complete the checklist and file for future compliance audit.

The SY ICB will only fund hallux valgus surgery when the following criteria are met:

This procedure is **not** funded for cosmetic reasons or for asymptomatic or mild symptomatic hallux valgus.

<i>In ordinary circumstances*, referral should not be considered unless the patient meets one of the following criteria.</i>	Delete as appropriate	
Ulcer development over the site of the bunion or the sole of the foot OR	Yes	No
Evidence of severe deformity (over or under riding toes) OR	Yes	No
Significant and persistent pain when walking AND conservative measures (e.g. bunion pads / insoles / altered footwear) have failed to provide symptomatic relief in sensible shoes OR	Yes	No
Physical examination and X-ray show degenerative changes in the 1 st metatarsophalangeal joint, increased intermetatarsal angle and/or valgus deformity >15 degrees	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information. If patient meets the above criteria then prior approval is not required.*