

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

Please send this form with the referral letter.

Male Circumcision

Instructions for use:

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

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

<i>In ordinary circumstances*, referral should not be considered unless the patient meets one or more of the following criteria.</i>	Delete as appropriate	
Phimosis (inability to retract the foreskin due to a narrow prepuce ring) or recurrent paraphimosis (inability to pull forward a retracted foreskin)	Yes	No
Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)	Yes	No
Balanoposthitis (recurrent bacterial infection of the prepuce).	Yes	No
Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	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.*

This policy does not apply to:

- Penile malignancy. Use the 2ww cancer referral pathway
- Traumatic foreskin injury where it cannot be salvaged