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

Please send this form with the referral letter.

Blepharoplasty

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 CCG will only fund blepharoplasty 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**	
Does the patient complain of symptoms of blepharospasm or significant dermatitis on the upper eyelid caused by redundant tissue?	Yes	No
Did the patient develop symptoms following skin grafting for eyelid reconstruction?	Yes	No
Did the patient develop symptoms following surgery for ptosis?	Yes	No

** If the patient does not fulfil these criteria but the clinician feels there are exceptional circumstances please refer to the Individual funding request policy for further information. If patient meets the above criteria then prior approval is not required.*

If the above criteria are not met, does the patient meet ALL of the following exceptions:–

Is there documentation that the patient complains of interference with vision or visual field related activities such as difficulty reading or driving due to upper eye lid skin drooping, looking through the eyelids or seeing the upper eye lid skin **AND**	Yes	No
Is there redundant skin overhanging the upper eye lid margin and resting on the eyelashes when gazing straight ahead **AND**	Yes	No
Evidence from visual field testing that eyelids impinge on visual fields reducing field to 120° laterally and/or 20° or less superiorly	Yes	No