**Individual Funding Request (IFR) Form** Restorative Dentistry

|  |
| --- |
| **PATIENT DETAILS** |
| First name(s) |  | Request date |  |
| Surname |  | Male[ ]  | Female [ ]  |
| Address |  |
| Town |  | Date of birth |  |
| Postcode |  | NHS number |  |
| **REFFERING PRACTITIONER DETAILS** |
| Name |  | GDC/GMC no. |  |
| Designation |  |
| Name of practice (if GDP) |  |
| Provider trust (if salaried service) |  |
| Address |  |
| Telephone |  |
| Email address (NHS.net only) |  |
| **GENERAL DENTAL PRACTITIONER DETAILS (IF NOT REFERRER)** |
| Name |  | GDC no. |  |
| Designation |  |
| Name of practice (if GDP) |  |
| Provider trust (if salaried service) |  |
| Address |  |
| Telephone |  |
| Email address (NHS.net only) |  |
| **CONSENT** |
| I confirm that this Individual Funding Request (IFR) has been discussed in full with the patient. The patient is aware that they are consenting for the individual IFR Team to access confidential clinical information held by clinical staff involved with their care about them as a patient to enable full consideration of this funding request. |   Yes / No |
| Please note: NHS England is under obligation to let the patient know the outcome of all IFR applications. The patient and parent/guardian or career will therefore be copied into correspondence between the clinician and NHS England unless it is not clinically appropriate to do so. Please indicate as follows:I confirm that it is clinically appropriate for the patient to be copied into all correspondence. |  Yes / No |
| Signature of Requester:  |  | Date: |  |

**Referral criteria guidelines**

|  |
| --- |
| On an individual basis, there may be situations where a clinician believes that their patient’s clinical situation is so different to other patients with the same condition that they should have their treatment paid for when other patients would not. In such cases, NHS clinicians can ask NHS England, on behalf of a patient, to fund a treatment which would not usually be provided by NHS England for that patient.NHS England will only provide funding in response to an IFR, if it is satisfied that the case meets the following criteria:There is evidence that the patient presents with exceptional clinical circumstances, that is:There is an NHS England clinical commissioning policy, [NICE Technology Appraisal (TA) guidance](https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance) or [Highly Specialised Technology (HST) Appraisal guidance](https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-highly-specialised-technologies-guidance) that governs whether to fund or not fund the treatment for the patient's condition, and a clinician can show that their patient is in a different clinical condition when compared to the typical patient population with the same condition and (if relevant) at the same stage of progression, and because of that difference their patient is likely to receive material additional clinical benefit from treatment that would not be plausible for any typical patient.ORThere is not a relevant NHS England clinical commissioning policy NICE Technology Appraisal (TA) guidance or Highly Specialised Technology (HST) Appraisal guidance in place for the management of the patient's condition or combination of conditions, and the patient’s clinical presentation is so unusual that they could not be considered tobe part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken.ANDThere is a basis for considering that the requested treatment is likely to be clinically effective for this individual patient.ANDIt is considered that the requested treatment is likely to be a good use of NHS resources.**If you are not sure if your case is exceptional then the case should be sent to into your regional Hospital for Consultant advice and opinion.**If your patient falls into the following priority groups, they would be considered appropriate for referral for advice and, if necessary, specialist treatment within the Hospital services:1. Head and Neck Oncology patients2. Development defect, such as cleft lip and palate; hypodontia; and complex dental anomalies3. Trauma: severe trauma involving the dentoalveolar complex**These cases should not have an IFR completed but should be referred via the normal pathway** **into your regions Hospital Dental department for Consultant assessment.** |
| **REVIEW OF GUIDELINES** |
| I have read the above information and believe my patient has an exceptional circumstance? YES [ ]  NO [ ] I have already sent the patient for Consultant advice? (Letter must be included) YES [ ]  NO [ ] The patient does not fall into Hospital priority groups for treatment? YES [ ]  NO [ ] There is no local Hospital which can provide this exceptional treatment? YES [ ]  NO [ ] *Please note if any of the above answer are* ***No*** *your application may be automatically rejected* |

**Type of request**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **RESTORATIVE** |  | **ENDODONTIC** |  | **PERIODONTAL** |  | **DENTURE** |  |

**Medical/Social history (This should be as comprehensive as possible)**

|  |  |
| --- | --- |
| GMP Name |  |
| GMP Practice Address |  |
| GMP Telephone number |  |
| **MEDICAL CONDITIONS** |
|  |
| List all medications being taken |
|  |
| Smoker |  Yes [ ]  | No [ ]  | If yes, number smoked per day |  |
| Alcohol consumption | Yes [ ]  | No [ ]  | If yes, number of units consumed per week |  |
| Other (para-function/habits, etc) |  |

**Treatment requested**

|  |
| --- |
| **DIAGNOSIS** |
| Please tick to confirm that patients primary dental disease is stable: No active caries, no acute infections, untreated periodontal disease☐ |
| **Please list treatment requested:** |
|  |
| **CLINICAL INFORMATION** |
| **Patient history:** |
| Patient attendance history | Regular attender | Irregular attender | Attends in pain only |
| Dates patient attended appointments over the last 2 years: |  |
| **EXAMINATION** |
| **Extra oral:**Skeletal Classification: I / II / IIIMuscles of mastication tender to palpation: Yes / No Site ………………….Lymph nodes: Yes / No Site ………………………………….Competent lip seal: Yes / No |
| **Intra oral:**RL**Teeth Present:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Oral mucosa healthy**: Yes/No**Oral hygiene**: Good / Fair / Poor**BPE:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |

 |
| **ADDITIONAL INFORMATION*****Radiographs, photos and study models are essenital for most cases; if not included your referral may be rejected.*** |
| Radiographs taken and included YES [ ]  NO [ ]  Reason if No:Photographs included YES [ ]  NO [ ]  Reason if No:Study models included YES [ ]  NO [ ]  Reason if No: |

**Supporting information**

|  |
| --- |
| **OUTLINE PREVIOUS TREATMENT PROVIDED** |
| *If referring for periodontal treatment : include classification of disease and two 6 point pocket charting records*  |
| **RESPONSE TO PREVIOUS TREATMENT PROVIDED** |
|  |
| **EFFECT FOR PATIENT IF REQUESTED TREATMENT IS NOT PROVIDED** |
|  |
| **Why are the standard alternative treatments that could benefit the patient not been appropriate in this case?****patient?** |
|  |

**Exceptionality**

|  |
| --- |
| To meet the definition of ‘exceptional clinical circumstances’ your patient must demonstrate that they are both: * Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition
* Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition
 |
| **Please state the reasons for this patient to have exceptional clinical circumstances:** |
| Clinicians are required to disclose all material facts to NHS England as part of this process.Are there any other comments/ considerations that are appropriate to bring to the attention of the IFR Team? |
|  |
| Signature of requester: |  | Date: |  |

**Affordability (To be completed by secondary care referrers only)**

|  |
| --- |
| **Which Consultant has planned and agreed to the IFA application for this case?** |
| Consultant Name & GDC/GMC |  |
| Consultant Signature |  |
| Date treatment plan made by Consultant |  |
| **If a Constant has not been involved with the treatment plan please tick this box** [ ]  |
| **How will the treatment be provided to the patient?** |
|  |
| **How long is the anticipated treatment requested likely to take?** **(possible number of appointments and number of months)** |
|  |
| **What is the cost of the requested treatment?** |
|  |

Please complete and return this form to: england.swdental@nhs.net

If your referral is urgent, and needs consideration quickly in the subject title of your email write:

**URGENT IFR sent on XX/XX/20XX**