

**Exceptional Circumstances Submission Form**

**(Mental Health Individual Funding Requests)**

**On completion please send to: ny.mentalhealthifr@nhs.net**

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| **CCONTACT INFORMATION** |  | | | |
| 1. Referring Clinician | **GP/Consultant Name:** | |  | |
| **GP Name (if different to referring clinician)** | |  | |
| **Practice/Hospital name and address:** | |  | |
| **Tel:** | |  | |
| **Fax:** | |  | |
| **Email:** | |  | |
| **Provider referred to:** | |  | |
| 1. Patient Details | **NHS Number:** | |  | |
| **Date of referral to exception panel:** | |  | |
| 1. Patient Diagnosis | |  | | |
| 1. Intervention Requested | |  | | |
| 1. Significant clinical history   e.g. duration of symptoms, co-morbidities | |  | | |
| 1. Give details of relevant treatment/management/ investigations carried out in primary/secondary care (in accordance with the relevant clinical thresholds) | |  | | |
| 7. Please describe the **clinical**  need for this intervention | |  | | |
| 8. Please explain why this  patient is likely to have  exceptional benefit from  this intervention, i.e.  significantly more benefit  from this intervention than  might be expected for the  average patient with that  particular condition. | |  | | |
| 9. What would be the  estimated impact of  denying access to the  intervention on; mobility,  self-care, pain/discomfort,  anxiety/depression? | |  | | |
| 10. Patient has given consent to share information to all organisations involved in this process (please tick box to confirm) | | | |  |

**Please ensure that you enclose a copy of the referral letter with this form.**

**The referral cannot be considered unless all relevant information is included.**