☐ **NHS Calderdale Clinical Commissioning Group**
☐ **NHS Greater Huddersfield Clinical Commissioning Group**
☐ **NHS North Kirklees Clinical Commissioning Group**

**** Please tick the relevant box above indicating which Clinical Commissioning Group has funding responsibility for the patient detailed below ****

Individual Funding Request

Referral Form

This form should be completed by the clinician with the most knowledge of the intervention / procedure that is being requested and the most knowledge of the patient that it is being requested for.

<table>
<tr><td rowspan="2">Patient's Name:</td><td>DOB:</td></tr>
<tr><td>NHS no:</td></tr>
<tr><td colspan="2">Patient's Address (include postcode):</td></tr>
<tr><td colspan="2">DETAILS OF REQUEST AND SUPPORTING INFORMATION
Please ensure that all relevant information is included in this form or is attached to ensure that requests are processed in a timely manner</td></tr>
<tr><td colspan="2">Request for:</td></tr>
<tr><td colspan="2">BMI measurement:</td></tr>
<tr><td colspan="2">If the BMI measurement is >30, has the patient been offered advice or onward referral to any weight management support programmes?</td></tr>
<tr><td colspan="2">Does the patient smoke: YES / NO

If yes, has the patient been offered advice or onward referral to a Smoking Cessation programme?</td></tr>
</table>

Clinical information:
Options tried:
Evidence base to support request:

What clinical outcomes are requested?

Is the requested intervention required to be performed within a strict time-frame? If YES, please provide further evidence;

Would undue delay result in a real and imminent risk of harm? If YES, please provide further evidence;

Evidence to support that this individual is exceptional when compared to other individuals with the same clinical presentation;

Costs (if known):

Provider (if known):

For equipment requests, please ensure that 3 comparable quotes are attached

Please ensure that Appendix A – Equality Monitoring Form is completed by the patient and is attached to this funding request prior to submission

I confirm that I have discussed this referral with the patient and in line with GDPR have informed the patient how their information will be processed. The patient has given consent for their information to be shared with the IFR Team at Greater Huddersfield CCG.

Signed: Date:

Please print name:

Position & address of referring clinician (Practice stamp) & GP Practice if different:

Details of where to send this form **(Please mark as CONFIDENTIAL)**

Individual Funding Requests Team
Greater Huddersfield Clinical Commissioning Group
Broad Lea House, Bradley Business Park, Dyson Wood Way, Bradley, Huddersfield**,**
HD2 1GZ

Telephone: 01484 464438
Safe Haven email: GHCCG.IFR-CKW@nhs.net
Safe Haven fax: 01484 464062

(Please see over the page for Appendix A – Equality Monitoring Form)

Appendix A – Equality Monitoring Form – Patient

To make sure we provide the right services and treat everyone fairly, it is important we collect the following information. Data will be protected and stored securely in line with data protection rules. This information will be kept confidential. We would like you to answer all the questions but it is not required. (**The answers to these questions will not affect the decision of the Individual Funding Request that is being submitted by your clinician).**

1. What sex are you?

☐ Male ☐ Female

☐ Prefer not to say

2. Which country were you born in?

☐ Prefer not to say

3. Do you belong to any religion?

☐ Buddhism
☐ Christianity
☐ Hinduism
☐ Islam
☐ Judaism
☐ Sikhism
☐ No religion
☐ Other (please specify in the box below)

☐ Prefer not to say

4. What is your ethnic group?

Asian or Asian British:

☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese
☐ Other Asian background (please specify in the box below)

Black or Black British:

☐ Caribbean
☐ African
☐ Other Black background (please specify in the box below)

Mixed or multiple ethnic groups:

☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Other Mixed background (please specify in the box below)

White:

☐ English/Welsh/Scottish/Northern Irish/British
☐ Irish
☐ Gypsy or Irish Traveller
☐ Other White background (please specify in the box below)

Other ethnic groups:

☐ Arab
☐ Any other ethnic group (please specify in the box below)

☐ Prefer not to say

Please turn over the page

5. Do you consider yourself to be disabled?

☐ Yes ☐ No

☐ Prefer not to say

Type of impairment:
Please tick all that apply

☐ **Physical or mobility impairment** (such as using a wheelchair to get around and / or difficulty using their arms)

☐ **Sensory impairment** (such as being blind / having a serious visual impairment or being deaf / having a serious hearing impairment)

☐ **Mental health condition** (such as depression or schizophrenia)

☐ **Learning disability** (such as Downs syndrome or dyslexia) or cognitive impairment (such as autism or head-injury)

☐ **Long term condition** (such as cancer, HIV, diabetes, chronic heart disease, or epilepsy)

☐ Prefer not to say

6. Are you a carer?

Do you look after, or give any help or support to a family member, friend or neighbour because of a long term physical disability, mental ill-health or problems related to age?

☐ Yes ☐ No

☐ Prefer not to say

7. Are you pregnant?

☐ Yes ☐ No

☐ Prefer not to say

8. Have you given birth in the last 6 months?

☐ Yes ☐ No

☐ Prefer not to say

9. Please select the option that best represents your sexual orientation?

☐ Bisexual (both sexes)

☐ Gay (same sex)

☐ Heterosexual/straight (opposite sex)

☐ Lesbian (same sex)

☐ Other

☐ Prefer not to say

10. Are you transgender?

Is your gender identity different to the gender you were assigned at birth?

☐ Yes ☐ No

☐ Prefer not to say

Thank you for completing this form