**Individual Funding Request (IFR) - Reconsideration form**

**(*TO BE SUBMITTED FOR FUNDING REQUESTS BASED ON CLINICAL EXCEPTIONALITY)***

Please only use this form when requesting a reconsideration of an Individual Funding Request or to request a process review following a decision taken at The GM IFR Panel

**REQUESTS FOR RECONSIDERATIONS WILL ONLY BE CONSIDERED WHERE THERE IS NEW SIGNIFICANT CLINICAL INFORMATION**

**INCOMPLETE FORMS PROVIDING INSUFFICIENT INFORMATION WILL BE RETURNED**

**(PLEASE ENSURE APPENDIX A – EVIDENCE PROFORMA IS COMPLETED AND SUBMITTED WITH THE REQUEST)**

**IMPORTANT INFORMATION**

**ALL REQUESTS MUST BE COMPLETED BY THE TREATING CLINICIAN**

**Before completing and submitting this form, you MUST first consider the following:**

**REQUEST FOR RECONSIDERATON**

* **Is there new significant clinical information which was not previously been considered by the GM IFR Team?**

If No, the reconsideration request will not be considered.

* **Has a clear clinical rationale been provided as to why a reconsideration of this individual Funding Request is being requested?**

If No, the reconsideration request will not be considered.

**NOTE: A REVERSAL OF A PREVIOUS DECISION CANNOT BE MADE ON THE BASIS OF INFORMATION THAT HAS ALREADY PREVIOUSLY BEEN CONSIDERED BY THE GM IFR PANEL / GM IFR TEAM**

**REQUEST FOR PROCESS REVIEW**

* **Has a key piece of information which was submitted with the original request not been taken into consideration by the GM IFR Panel?**

If YES, please clearly reference the information you believe was not considered

* **Are you, as the treating clinician of the opinion the process as outlined in the GM IFR Operating Policy was not followed by the GM IFR Service?**

If YES, please clearly demonstrate how you believe the process was not followed.

**Please refer to the GM IFR Team Operational Policy for more details. (**[GM IFR Operational Policy](https://gmeurnhs.co.uk/Docs/Other%20Policies/GM%20EUR%20Operational%20Policy.pdf))

**NOTE: A PROCESS REVIEW CAN ONLY BE CONSIDERED IF ONE OF THE ABOVE POINTS UNDER “REQUEST FOR PROCESS REVIEW” APPLIES TO THIS INDIVIDUAL FUNDING REQUEST.**

|  |  |  |  |
| --- | --- | --- | --- |
| **CONTACT DETAILS** | | | |
| **Treating clinician details** | | **Name:** | |
| **Designation:** | |
| **Organisation:** | |
| **Contact phone number:** | |
| **Secure email: (**[**e.g. @nhs.net**](mailto:e.g.@nhs.net)**):** | |
| **Patient details** | | **Name:** | |
| **Address:** |  |
| **Date of Birth:** | |
| **NHS Number:** | |
| **GP Practice and Post Code:** | |
| **GM IFR Reference Number:** | |
| **You MUST NOT use any patient, clinician or provider identifiers in the remainder of this form.**  **If any details are included in the remainder of the form, it will be returned for redaction to be undertaken by the requestor.**  **Before a request is reconsidered by the GM Individual Funding Request (IFR) Service any factors which are non-clinical or non-relevant clinical factors may be redacted.** | | | |
|  | | | |
| 1. **REQUEST FOR RECONSIDERATION**   **Please complete this section if the treating clinician is requesting a reconsideration because there is new significant clinical information and a clear clinical rationale has been provided in support of the reconsideration.** | | | |
| 1. **Details of intervention / drug requested** | *Please provide details and original IFR reference number* | | |
| 1. **Has there been a change in the patient’s clinical presentation since the original application was submitted?** | Choose an item.  *If Yes, please provide details and attach the relevant documentation to support this* | | |
| 1. **Please provide details of what new significant clinical information and/or evidence is being submitted in support of this reconsideration** | *Please ensure ALL relevant clinical documents / evidence are attached to this request* | | |
| 1. **Are there any other comments and/or considerations that are appropriate to bring to the attention of the GM IFR Team?** | Choose an item.  *If Yes, please provide details* | | |
| 1. **Is the request time critical? If so, when should treatment commence?**   ***(Please see*** [GM IFR Operational Policy](https://gmeurnhs.co.uk/Docs/Other%20Policies/GM%20EUR%20Operational%20Policy.pdf) ***for more details, including definition of urgency)*** | Choose an item.  Click or tap to enter a date.  If the case urgent then please state clinical reason why:  ***Note: Treatment undertaken before the application is received will not be funded retrospectively but if further or ongoing treatment is needed, it will be considered for approval.*** | | |
| 1. **REQUEST FOR PROCESS REVIEW**   **Please complete this section if the treating clinician is requesting a process review because they are of the opinion the process as outlined in the GM IFR Operating Policy was not followed by the GM IFR Service.** | | | |
| 1. **What are the reasons for requesting a process review? (Please use both boxes if more than one reason applies)**   ***This must include which element(s) of the process were not followed and/or which piece of evidence was not considered by the GM IFR Panel.*** | Choose an item.  Choose an item.  *Please provide as much detail as possible in the box below and ensure ALL supporting document(s) are attached to the request.* | | |
| **DECLARATION OF INTERESTS** | | | |
| 1. **Clinicians are required to disclose all material facts as part of the process. Are there any other comments/considerations that are appropriate to bring to the attention of the IFR Team?** | | **YES**  **NO** | |

**CONSENT**

|  |  |
| --- | --- |
| **I confirm that this IFR has been discussed in full with the patient. The patient is aware that they are consenting for the 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 without patient consent funding requests are unable to be reviewed. All personal information will be removed prior to the consideration by the IFR panel.**  **Signature of referring clinician:**       **Date:** Click or tap to enter a date. |
|  | |
| **Decisions are routinely communicated to the named referring clinician stated in ‘referrer details’ i.e. the clinician taking overall clinical responsibility for the requested treatment. If another healthcare professional for the purpose of patient care requires a copy of the decision outcome correspondence, e.g. senior Trust pharmacist this can be facilitated on provision of a valid nhs.net address.** | **Name:** |
| **Designation:** |
| **SECURE email:** |

**Please send the fully completed form to the GM IFR Team via secure email:** [**gm.eur@nhs.net**](mailto:gm.eur@nhs.net%20)

**APPENDIX A**

**Evidence Proforma**

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| Please provide reference to the key evidence for clinical exceptionality, clinical effectiveness, good use of resources and safety of this procedure/treatment in each of the papers submitted as part of the evidence base relevant to this application. | | | |
| **No.** | **Title submitted**  **paper** | **Topics** | **Specific sections with key evidence (page number/paragraph or section)** |
| 1. | Article one | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |
| 2. | Article two | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |
| 3. | Article three | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |
| 4. | Article four | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |
| 5. | Article five | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |
| 6. | Article six | Clinical exceptionality |  |
| Clinical effectiveness |  |
| Good use of resources |  |
| Safety of this  procedure/treatment |  |