# Individual Funding Request (IFR) Form – Orthodontics

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| Patient Details | | | | | | | |
| First name(s): |  | Request date: | | |  | | |
| Surname: |  | Male | | | Female | | |
| Address: |  | | | | | | |
| Town: |  | Date of birth: | | |  | | |
| Postcode: |  | NHS number: | | |  | | |
| REFERRING PRACTITIONER DETAILS | | | | | | | |
| Name: |  | GDC/GMC no: | | |  | | |
| Designation: |  | | | | | | |
| Name of practice (if GDP/Orthodontist): |  | | | | | | |
| Provider trust (if salaried service): |  | | | | | | |
| Address: |  | | | | | | |
| Telephone: |  | | | | | | |
| Email address (NHS.net only): |  | | | | | | |
| PREVIOUS PRACTITIONER DETAILS (IF ORTHODONTIC CoT previously STARTED) | | | | | | | |
| Name: |  | | GDC no: | | |  | |
| Designation: |  | | | | | | |
| Name of practice (if GDP/Orthodontist): |  | | | | | | |
| Provider trust (if salaried service): |  | | | | | | |
| Address: |  | | | | | | |
| Telephone: |  | | | | | | |
| Email address (NHS.net only): |  | | | | | | |
| GENERAL DENTAL PRACTITIONER DETAILS (IF NOT the 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 Referrer:** |  | **Date:** | |  | | | |

## Referral criteria guidelines

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| --- | --- |
| 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.  **OR**  There 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 to be part of a defined group of patients in the same or similar clinical circumstances for whom a service development should be undertaken.  **AND**  There is a basis for considering that the requested treatment is likely to be clinically effective for this individual patient.  **AND**  It 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 only.** | |
| REVIEW OF GUIDELINES | |
| I have read the above information and believe my patient has an exceptional circumstance? | Yes  No |
| I am willing to provide the treatment stated below. | Yes  No |

## Type of request

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| First Course of Treatment  Additional Course of Treatment  Other |
| If other please explain here: |

## 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: |  |

## Treatment requested

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please provided a summary of treatment requested:** | | | | |
|  | | | | |
| **Please provide a summary of treatment history if applicable:** | | | | |
|  | | | | |
| Additional Information  Records to include notes, radiographs, photos and digital scans of study models are essential for most cases; if not included your referral may be rejected. | | | | |
| Clinical notes | | | | Yes  No |
| Radiographs taken and included | | | | Yes  No |
| Photographs included | | | | Yes  No |
| Digital scans of study models included | | | | Yes  No |
| **SUPPORTING INFORMATION** | | | | | | |
| IOTN (Index of Orthodontic Treatment Need)  **or**  IOFTN (Index of Orthognathic Functional Treatment Need) | |  | Date of Assessment |  | | |
| Eligible for NHS Treatment | | | | Yes ☐ No ☐ | | |
| The patient is motivated to wear appliances | | | | Yes ☐ No ☐ | | |
| The oral hygiene is excellent | | | | Yes ☐ No ☐ | | |
| The patient has good dental health and is caries free | | | | Yes ☐ No ☐ | | |
| **Why are the standard alternative treatments that could benefit the patient not appropriate in this case?** | | | | | | |
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## Exceptionality

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| --- | --- | --- | --- |
| 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 panel? | | | |
|  | | | |
| Signature of requester: |  | Date: |  |

Please return the completed form to: [england.swdental@nhs.net](mailto:england.swdental@nhs.net)

Secondary Care referrers only – please complete the following page.

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

|  |  |
| --- | --- |
| **Which Consultant has planned and agreed to the IFR application for this case?** | |
| Consultant Name & GDC/GMC: |  |
| Consultant Signature: |  |
| Date treatment plan made by Consultant: |  |
| **If a Consultant 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 return the completed form to: [england.swdental@nhs.net](mailto:england.swdental@nhs.net)