Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Surgery for Ingrown Toenails

Instructions for use:
Please refer to policy for full details, complete the checklist and file for future compliance audit.

The CCG will only fund surgery for ingrown when the following criteria are met:

*In ordinary circumstances**, referral should not be considered unless the patient meets **one** of the following criteria.*	**Delete as appropriate**	
Patient is in clinical need of surgical removal of ingoing toe nail has been seen by a community podiatrist and has a documented allergic reaction to local anaesthetic preventing treatment in the community and a general anaesthetic will be needed.	Yes	No
Patient has infection and/or recurrent inflammation due to ingrown toenail **AND** has high medical risk*.	Yes	No

**Medical risk is determined by the referring clinician - including, but not limited to, vascular disease, neurological disease or diabetes which are categorised as having high medical need due to the risk of neuropathic complications.*

***If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*