**Ganglion Cyst interventions Referral Proforma**

Individual funding is required prior to any Ganglion cyst surgery if a patient does not meet the exceptionality criteria in the Surgery for ganglion cyst Commissioning policy. It is the responsibility of referring and treating clinicians to ensure compliance with the New Devon CCG Commissioning Policies. Click [here](https://northeast.devonformularyguidance.nhs.uk/referral-guidance/commissioning-policies/wrist-ganglia-removal) to access the policy.

**NOTE for Primary Care Clinician:-**

Please note that there is a [Clinical Referral Guideline](https://northeast.devonformularyguidance.nhs.uk/referral-guidance/eastern-locality/musculosketal/ganglia-and-myxoid-cysts) to support ganglion management in primary care. This includes information on red flags (for sarcomas) and differential diagnoses. Patients should be made aware that most ganglion resolve spontaneously over time and that excision carries risks eg scar tenderness, stiffness, numbness and the likelihood of recurrence.

* Policy criteria **met** as appropriate to intervention complete sections 1-2. If criteria are not met the referral will be returned to the referrer
* Hospital specialist/treating clinician to complete Section 3

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| **Patient Details: Section 1** | | | |
| **NHS Number:** | <NHS number> | **Date of Birth:** | <Date of birth> |
| **Surname:** | <Patient Name> | **Title:** | <Patient Name> |
| **Forenames:** | <Patient Name> | | |
| **Address:**  **<Patient Address>** | | | |
| **Postcode:** | <Patient Address> | **Email Address:** | <Patient Contact Details> |
| **Preferred Tel:** | <Patient Contact Details> | **Home Tel:** | <Patient Contact Details> |
| **Mobile Tel :** | <Patient Contact Details> |
| **Referring GP Details:** | | | |
| **Name:** | <Sender Name> | **Registered GP:** | <GP Name> |
| **Practice:** | <Organisation Address> | | |
| **Tel No:** | <Organisation Details> | **Fax No:** | <Organisation Details> |

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| **Policy Criteria: Section 2** | | | |
| Surgery for removal of a ganglion or myxoid cyst will only be offered if the patient meets the following criteria: | | Select boxes as appropriate | |
| 1 | Significant pain or significant functional impairment, defined as a loss or absence of an individual’s capacity to meet personal, social or occupational demands. Please give details:  Please enter text:- | |  |
| 2 | Mucoid (myxoid) cyst at distal interphalangeal joint (DIP) which recurrently discharge. Please give details:  Please enter text:- | |  |

**Past Medical History:**

<Problems>

<Summary>

**Current Medication:**

<Medication>

<Repeat Templates>

**Allergies:**

<Allergies & Sensitivities>

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| **Referral for potential routine surgery *latest info available on Formulary and Referral website:*** [**N/E**](https://northeast.devonformularyguidance.nhs.uk/referral-guidance/key-messages/in-shape-for-surgery) [**S/W**](https://southwest.devonformularyguidance.nhs.uk/referral-guidance/key-messages/in-shape-for-surgery) | | | | | |
| Do you expect this referral to result in routine surgery? | | | | |  |
| Has patient been fully, or best, optimised for potential surgery as per medical markers below? | | | | |  |
| If not please provide detail below: | | | | | |
| Has patient previously been discharged solely for optimisation for this surgery?  If yes, please include copy of discharge letter. | | | | |  |
| **Referral Metrics: *These are helpful (but not mandatory) to support “In shape for surgery” for the agreed specialties/procedures*** | | | *Please include date of latest entry for metrics* | | |
| The following metrics need to be within the last 3 months for routine surgery | | | | *Patient not fully optimised if:* | |
| Blood Pressure | | <Blood Pressure Configurable(table)> | | *BP > 160/100mmHg* | |
| Pulse | | <Numerics> | | *AF rate >100.* | |
| Has the patient been auscultated for heart murmur? | |  | |  | |
| Has any murmur detected been investigated? | |  | |  | |
| Haemoglobin | | <Numerics> | | *Hb < 130g/L male or*  *Hb < 120g/L female*  *(not related to chronic disease)* | |
| Is patient diabetic? | | <Diagnoses> | | *---* | |
| Is patient at high risk of diabetes? *(BMI > 30)* | |  | | *---* | |
| HbA1c (if diabetic or high risk of diabetes) | | <Numerics> | | *HbA1c > 69mmol/mol* | |
|  | | | | *Threshold for referral* | |
| Smoking Status (required for New Devon CCG optimising referrals LES) | <Diagnoses> | | | *---* | |
| If smoker, has patient been advised that they should ideally be smoke free for 8 weeks prior to surgery? |  | | | *---* | |
| Body Mass Index (BMI) (required for New Devon CCG optimising referrals LES) | <Latest BMI> | | | *---* | |

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| **Section 3: For Completion by Hospital Specialist/Treating Clinician** | | |
| I confirm that the patient meets the stated Policy or exceptionality criteria above: **<NHS number>** | | |
| Name of Hospital Specialist/Treating Clinician |  | Date: |