PRIOR APPROVAL REQUEST

Labiaplasty, Vaginoplasty & Hymenorrhaphy

Hertfordshire and west Essex Evidence Based Intervention policies can be viewed at <https://www.hweclinicalguidance.nhs.uk/clinical-policies>

Please complete and return this form along with clinic letter/supporting evidence to:

For Hertfordshire patients [priorapproval.hweicb@nhs.net](mailto:hweicbwe.funding@nhs.net) Tel: 01707 685354

**Labiaplasty and/or vaginoplasty should only be commissioned when medically necessary AND secondary to another underlying medical condition. If a clinician wishes to refer the patient to secondary care, funding must be approved by the ICB and will only be considered in the following circumstances. Funding applications must include a clear description of the patient’s condition. The submission of medical photography may be requested but is optional. Surgery will only be considered for adults (over 18), excluding cancer cases.**

**Genital reconstruction for gender dysphoria is outside of the scope of this policy.**

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| **Patient consent** | This application has been discussed with the patient and the patient consents to relevant information being shared with the ICB. | Please tick |

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| **Date form completed** |  | |
| **Urgency** | Routine (5 Working day turnaround time)  Urgent (2 working day turnaround time)  **Note: An urgent request is one in which a delay may put the patient’s life at risk. Turnaround times commence the working day after receipt of the funding application.** | |
| **Patient details Please complete all or attach patient sticker** | Name: Address:  Telephone number: NHS No:  Hospital No: | Date of birth: - - / - - / - - - - |
|  | GP Name: | Practice: |
| **Applying Clinician’s details** | Consultant Name:  Contact details: (Including email) | Hospital/Organisation: |
| **Declaration** | I declare that the information provided is, to the best of my knowledge, true and I am aware that this procedure may be subject to clinical audit. | |

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| **Vaginoplasty** | 1. Congenital absence or significant development/endocrine abnormalities of the vaginal canal   **OR** 2. Where repair of the vaginal canal is required after severe physical trauma (common consequences of childbirth will not be a sufficient reason) 3. **AND** the patient is over 18 years old 4. **AND** in all cases evidence is included in attached referral letter/clinic letters |

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| **Labiaplasty Hymenorrhaphy** | 1. Where repair of the labia is required after severe physical Trauma (common consequences of childbirth will not be a sufficient reason)  **OR** 2. Secondary to Cancer (NB – prior approval is not necessary for immediate management of cancer)   **OR** 3. Secondary to significant congenital malformation (this would not include cosmetic issues such as large labia) or endocrine abnormalities such as adrenal hyperplasia or Turners syndrome. 4. **AND** the patient is over 18 years old 5. **AND** in all cases evidence is included in the attached referral letter/clinic letters |
| **Hymenorrhaphy** | **Hymenorrhaphy** – As per the health and Care Act 2022 it is an offence to carry out Hymenoplasty (reconstruction of the hymen) with or without consent. It is also an offence to aid or abet a person to carry out Hymenoplasty. |

For patients where the criteria are not met and it can be demonstrated that there is an exceptional healthcare need, an Exceptional Case Request Form can be submitted to the IFR team.

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| **Shared Decision Making** | Patients should be supported with their decisions. Resources that can support implementation of shared decision making can be found on the NHS England website: <https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/> |

HWE ICB Fitness for Elective Surgery policy criteria

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| **Smoking status** | Never smoked Current smoker Ex-smoker – date last smoked: - - / - - / - -  For patients who currently smoke or have stopped smoking less than 8 weeks ago, please tick to show that you have made your patient aware that they will need to have stopped smoking or switched to e-cigarettes for at least 8 weeks prior to surgery |

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| **Measurements** | Height: ……….cm Weight: …………kg BMI kg/m²  **BMI >40 –** Patients are expected to reduce their weight by 15% or BMI <40 (whichever is greater).  **BMI 30 40 -** Patients are expected to lose 10% of their weight or reduce BMI to <30.  If the patient has already achieved their target weight loss in the last 9 months, please give details of previous recorded measurements and the date recorded by clinician or, attach referral coversheet from GP or community provider.  Previous Weight: ………..kg Previous BMI kg/m²  Date measured - - / - - / - - - - % weight reduction = ………….  For surgery other than hip, knee or spinal, where the patient’s BMI is 30 to 40 and metabolic syndrome has been actively excluded in the last 18 months, please attach copy of evidence from GP or Community referral form.  At 9 months, if the patient has not met their target weight and/or stopped smoking, they should be reassessed for their need for- and fitness for- surgery.  See the Fitness for Elective Surgery policy at <https://www.hweclinicalguidance.nhs.uk/clinical-policies/fitness-for-surgery/> |