**NHS Cheshire and Merseyside Integrated Care Board (ICB)**

**Individual Funding Request (IFR)**

**Reconsideration Form**

Complete this form if you are the referring clinician and believe the IFR team have not considered everything relevant when they made the decision, and you have additional information to submit that was not previously considered.

If you are the referring clinician and believe the IFR team have not followed the correct process to reach their decision, DO NOT complete this form. Instead, please download, complete and submit an IFR Process Review/Appeal application form.

All sections of the form must be completed and typewritten otherwise the case will not be considered.

**Important Information**

Applicants are advised to review the General Policy for IFR and the IFR Process.

It is the responsibility of the referring clinician to ensure all the appropriate required clinical information is provided. This includes full text copies of all the published papers of clinical evidence that have been cited, a list of the published papers submitted and an indication of which points within them are relevant in respect to the IFR application criteria. Requests will only be considered on the information provided in the application and supporting papers.

**DO NOT** include patient or Trust/requesting clinician identifiable data in any free text sections. Where there are large amounts of identifiable data included in the application will be returned to you for redaction and resubmission.

**Please note:** Applications presenting incomplete information will be returned for amendment/completion prior to consideration.

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| **SECTION 1 – EXISTING CASE ID NUMBER** | |
| **1a. Case ID number:** | Click or tap here to enter text. |

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| **SECTION 2 – AREA** | | |
| **2a. Please indicate the location of this patient** | Cheshire East  Cheshire West  Halton  Knowsley  Liverpool | Sefton  St Helens  Warrington  Wirral |

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| **SECTION 3 – PATIENT PERSONAL DETAILS** | | | |
| **3a. Patient Surname:** | Click or tap here to enter text. | **3e. NHS Number:** | Click or tap here to enter text. |
| **3b. Patient Forename:** | Click or tap here to enter text. | **3f. Hospital Number:** | Click or tap here to enter text. |
| **3c. Patient Middle Name(s):** | Click or tap here to enter text. | **3g. Patient Ethnic Origin:** | Click or tap here to enter text. |
| **3d. Patient Date of Birth:** | Click or tap here to enter text. | **3h. Patient Sex (M/F):** | Male Female  Mx  Click or tap here to enter text. |
| **3i. Patient Address:**  **(Including Postcode)** | Click or tap here to enter text. | | |
| **Please note that all unnecessary personal information will be removed from this form prior to being reviewed. This information is collected for monitoring purposes only)** | | | |

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| **SECTION 4 – REQUEST URGENCY** | |
| **4a. Indicate the level of clinical urgency for this request.** | ☐ Not urgent  ☐ Urgent - state reasons:  **State reasons:** Click or tap here to enter text. |
| **4b. Proposed start date or date treatment commenced:** | Click or tap here to enter text. |
| **Processing requests takes on average 30 working days.**  **If the case is more urgent than this, please state why and how urgent the case is.** | |

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| **SECTION 5 – UPDATED INFORMATION NOT ORIGINALLY INCLUDED IN THE IFR APPLICATION** | |
| **5a. Request details:** | Click or tap here to enter text. |
| **5b. Treatment:** | Click or tap here to enter text. |
| **5c. Clinical Background:** | Click or tap here to enter text. |
| **5d. Clinical Exceptionality\*:** | Click or tap here to enter text. |
| **5e. Clinical Supporting Information:** | Click or tap here to enter text. |
| Please note: Only include information that was NOT provided in this section of the original application form.  *\*NB. Clinical Exceptionality is defined as “the patient has a clinical picture that is significantly different to the general population of patients with that condition and as a result of that difference; the patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.”*  **Please explain how the patient’s clinical circumstances meet this definition.** | |

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| **SECTION 6 – SUBMIT**  **When you are satisfied that you have completed all sections you will need to submit the request for consideration by the CCG’s IFR Team. If the team needs more information, they will email you to ask that you provide more details.** | |
| **Clinicians are required to disclose all material facts to the CCG as part of this process.**  **Are there any other comments / considerations that are appropriate to bring to the attention of the IFR Team?** | Click or tap here to enter text. |
| **Signature of clinician requesting reconsideration:** | Click or tap here to enter text. |
| **Date:** | Click or tap here to enter text. |

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| **On Completion** |
| |  | | --- | | **Email to** [**ifr.manager@nhs.net**](mailto:ifr.manager@nhs.net) **from a secure email account e.g. nhs.net:**  **In the event that you are unable to forward the application from a secure email address, the application can be posted to:**  CONFIDENTIAL  1829 Building – Mail Account  Individual Funding Request Team  Countess of Chester Hospital NHS Foundation Trust  Liverpool Road  CHESTER  Cheshire  CH2 1UL | |