**INFORMATION TO ACCOMPANY AN INDIVIDUAL FUNDING REQUEST (IFR) FOR**

**VARICOSE VEINS**

### PATIENT DETAILS

|  |  |
| --- | --- |
| **NAME** |  |
| **DATE OF BIRTH** |  | **NHS NUMBER** |  |
| **ADDRESS** |  |
| **REFERRING GP** |  |
| **BMI (taken within the last 6 months)** |  |

|  |  |  |
| --- | --- | --- |
| Have first line treatments been tried for at least six months (compression stockings, leg elevation, occupational factors, weight loss etc.)?  | YES | NO |

### ADDITIONAL INFORMATION

The interventional treatment of varicose veins will only be commissioned where one or more of the following clinical criteria are met in patients over 18 years of age:

**Please tick all the boxes that apply to your patient**

|  |  |
| --- | --- |
| Skin changes secondary to chronic venous insufficiency, for example pigmentation or venous eczema  |  |
| At least two episodes of documented superficial thrombophlebitis |  |
| Active or healed venous leg ulcers |  |
| Previous episode of bleeding from the varicosity |  |
| Symptomatic varicose veins (veins associated with troublesome symptoms, typically pain, swelling, heaviness and aching) |  |

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| --- |
| Please provide any other relevant information in support of your request: |

GP Signature ………………………………………… Date ………………………………..