NHS
Midlands and Lancashire Commissioning Support Unit

Individual Funding Request (IFR) Form

Request ID	***(Q's 1+2 IFR use only)***		
1	Unique identifier		
2	Date Received by IFR Team		
Please note, this form should be completed and signed by a GP or Consultant and should be used for all requests *other than* High Cost Drugs (HCD). HCD forms can be requested from……..			
Priority			
3a	Urgent or Routine?		
3b	Is this patient on an 18 week pathway?	Yes No	Commencement date?
Consent			
4	(a) Is patient happy for relevant personal/ clinical details to be shared with the IFR panel?	*(Note – certain details will need to be shared else funding requests will not be reviewed)*	
	(b) Is the patient happy for any relevant data to be used by the finance team for the purpose of payment for their treatment if approved?		
	(c) Is patient happy to be contacted by these details? Please state preferred contact - telephone, email or letter.	*(Patients should be aware that we cannot guarantee the security of all methods of communication)*	
Patient Details	*Patients should be aware personal and sensitive details will only be shared when necessary. Demographics are required to administer requests and supply funding (if approved). This will not be shared with a funding panel, as requests will be anonymised.*		
4	Patient details; Initials and surname Address and post code Date of birth Gender NHS Number		
5	Patients GP and contact details		

Referrer details			
6	Contact details of referring clinician, including Trust address		
Referral details			
7	Patient diagnosis		
8	Purpose of referral/referral reason	*e.g. is it for a second opinion; procedure; or new treatment*	
9	Brief summary of clinical condition/relevant past medical history/summary of relevant previous interventions – (please note – any irrelevant case notes should not be included)	*Please supply as much detail as possible about: severity, duration and prognosis*	
Treatment Details			
10	Treatment requested		
11	Proposed Provider		
12	What is the standard treatment and why is that not appropriate?		
13	Is this condition/ treatment covered in any national or local guidance?		
14	If so is the criteria met?		
15	If not, what are the exceptional circumstances?		

Clinical evidence		
16	Please provide any clinical evidence to support the effectiveness of this treatment i.e. NICE, RCT, D&T, other published work?	
Outcomes		
17	If approved, how will the outcomes be measured? What is the exit plan?	
18	If not approved, how will the treatment be managed?	
Costs		
19	Anticipated cost	
Signature of referring clinician:		
Date submitted:		

Please return this completed form to:

Individual Funding Request Team
Midlands and Lancashire Commissioning Support Unit
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ

Telephone Enquiries: 01244 650388
Fax: 01244 470380
Email: ifr.manager@nhs.net

For panel use only	
Funding approved – yes/no	
Reason(s) for approval/non-approval	
Further action/information required	