Patient Name:
Address:
Date of Birth:
NHS Number
Consultant/Service to whom referral will be made:

Please send this form with the referral letter.

Haemorrhoidectomy

Instructions for use:
To Referring Clinicians (e.g. GP's): Please refer to the above policy and complete the following form prior to referral.

To Receiving Clinician: Please refer to the full policy, and ensure there is evidence that the criteria selected are met. Please file for future compliance audit.

The CCG will only fund haemorrhoidectomy when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets the following criteria.*	Delete as appropriate	
Recurrent third or fourth degree haemorrhoids **OR**	Yes	No
Irreducible and large haemorrhoids with frequently reoccurring, persistent pain or bleeding **OR**	Yes	No
Failed conservative treatment (including non-operative interventions: rubber band ligation, injection sclerotherapy, infrared coagulation/photocoagulation, bipolar diathermy and direct-current electrotherapy.)	Yes	No

**If clinician considers need for referral/treatment on clinical grounds outside of these criteria, please refer to the Individual Funding Request policy for further information.*