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

Please send this form with the referral letter.

Male Circumcision

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 male circumcision when the following criteria are met:

In ordinary circumstances, referral should not be considered unless the patient meets **one or more** of the following criteria.*	Delete as appropriate	
Phimosis (inability to retract the foreskin due to a narrow prepucial ring) or recurrent paraphimosis (inability to pull forward a retracted foreskin)	Yes	No
Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin)	Yes	No
Balanoposthitis (recurrent bacterial infection of the prepuce).	Yes	No
Recurrent febrile urinary tract infections due to an anatomical abnormality as confirmed by a secondary care Consultant e.g. Urologist, Paediatrician	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.*
This policy does not apply to

- Penile malignancy. Use the 2ww cancer referral pathway
- Traumatic foreskin injury where it cannot be salvaged