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| C:\Users\an046027\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\KZSA4VCZ\gigc.jpg | **ALL WALES POLICY FOR MAKING DECISIONS ON INDIVIDUAL PATIENT FUNDING REQUESTS (IPFR)** |

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| --- |
| REQUEST FOR A REVIEW OF THE IPFR PROCESS APPLICATION FORM |

Please complete the following information, expanding the boxes as required. Please send the signed form in hard copy to the IPFR Team at the address detailed below. All forms need to be typed to avoid mistakes due to misreading of handwriting.

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| **DETAILS OF CLINICIAN REQUESTING THIS REVIEW (must be original requesting clinician)** | | |
| **NAME** | **CONTACT DETAILS** | |
| **SIGNATURE AND DATE** |
| **PATIENT DETAILS** | | |
| **PATIENT NAME** | **PATIENT ADDRESS** | |
| **DATE OF BIRTH** |
| **PATIENT NHS NUMBER** |
| **SIGNATURE & DATE** |
| **REQUEST DETAILS** | | |
| **CLEARLY EXPLAIN THE GROUNDS FOR YOUR REVIEW REQUEST AS SET OUT IN SECTION 8 OF THE IPFR POLICY AND THE REASONS WHY.** | | **PROVIDE THE IPFR NUMBER** |
| **PROVIDE THE DATE THE IPFR PANEL CONSIDERED AND DECLINED THE ORIGINAL REQUEST** |
| **OUTLINE ANY FURTHER INFORMATION RELEVANT TO THIS REQUEST THAT YOU FEEL THE REVIEW PANEL SHOULD CONSIDER** | | |

Please return completed form to:

Room 43, Llanfrechfa Grange House

Cwmbran

Torfaen

NP44 8YN