|  |  |
| --- | --- |
| NIAP Reference number |  |
| Intervention title |  |
| Date of final report |  |
| **CONTACT DETAILS:** | |
| Full name |  |
| Title |  |
| Phone number |  |
| Email |  |

|  |
| --- |
| 1. **How many patients have undergone the intervention within this reporting period, for what indications, and with what outcomes? (Please report by indication and include data on adverse events relating to the procedure)** |
|  |
| 1. **Have these outcomes been presented to a peer group during the period covered by this report? If yes, please note the meeting name and date(s).** |
|  |
| 1. **What other evaluation(s) of the procedure did you perform in this reporting period?** |
|  |
| 1. **Were all adverse events reported to and discussed at a relevant morbidity or mortality meeting?** |
|  |
| 1. **Were all adverse events reported in IIMS?** |
|  |
| 1. **Has there been any unforeseen clinical, resource or credentialing issues?** |
|  |
| 1. **Is the intervention still being performed? (If the intervention is no longer being performed, please indicate the date ceased and the reasons).** |
|  |
| 1. **Did the actual costs meet the estimated costs in the original NIAP application?** |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Costs** | **Estimated** | | **Actual** | | | **Up-front (in first year)** | **Ongoing p.a.** | **Up-front (in first year)** | **Ongoing p.a.** | | **Staffing** |  |  |  |  | | **Equipment** |  |  |  |  | | **Consumables / prosthesis / high cost disposables** |  |  |  |  | | **Education / training** |  |  |  |  | | **Space** |  |  |  |  | | **Total** |  |  |  |  |   **Provide detail if actual costs did not meet estimated costs:** |
| 1. **Do you wish to seek approval to undertake this intervention on an ongoing basis?** |
| **🞏 Yes, if yes continue to question 10 and seek additional approvals**  **🞏 No, if no, why?** |
| 1. **Expected number of procedures to be performed per annum (include facility name/s)** |
|  |
| 1. **Should approval be sought to perform the procedure at other SESLHD facilities?** |
|  |
| 1. **Is there any additional information you wish to provide?** |
|  |

**APPROVALS**

Please submit completed report to Clinical Governance and Medical Services Directorate via email once approvals have been attained: [SESLHD-ClinicalGovernanceandMedicalServices@health.nsw.gov.au](mailto:SESLHD-MedicalExecutiveDirectorate@health.nsw.gov.au)

For further information, please contact SESLHD Clinical Governance and Medical Services on Tel: 9540 8822

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | **Signatures:** |
| **Applicant** | **Name:** |  |  |
| **Date:** |  |
| **Department Head:** | **Name:** |  |  |
| **Date:** |  |
| **Comments** |  |

If you are seeking approval to undertake this intervention on a permanent basis, you will need the below additional approvals

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | **Signatures:** |
| **Program/ Service Line Director** | **Name:** |  |  |
| **Date:** |  |
| **Comments** |  |
| **Facility Director of Clinical Services** | **Name:** |  |  |
| **Date:** |  |
| **Comments** |  |

**Facility General Manager:**

GM Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a capped number of procedures per annum?

**No  Yes, detail:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Name:** |  |
| **Date:** |  |
| **Signature:** |  |