**This form is designed to provide Bupa with the information we need to determine eligibility for funding for the treatment of heavy menstrual bleeding in line with published evidenced-based guidelines**†**.**

Please complete all sections of the form. If the form is not fully completed we may not be able to reach a decision without contacting you further and this could result in an unnecessary delay. Bupa only funds treatment that is covered under the customer’s policy.

If you have any questions please call the Bupa Obstetrics and Gynaecology Specialist Support Team on 08456 00 86 36\*.

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name: |  | Bupa Membership Number: |  |
| Consultant name: |  | Bupa Provider Number: |  |
| Symptom history: (including start date) |  |
| Were primary care investigations in line with NICE Guideline CG44? | ⍻ Yes | ⍻ No |
| Please give details: | Please give details: |
| Diagnosis: |  |
| Primary care treatment, as per NICE guideline CG44, was followed | ⍻ Yes - please provide details of first and second line treatments below⍻ No – please give details below |
| Details of why NICE guideline CG44 was not followed |  |
| First line, including length of time trialled |  |
| Second line, including length of time trialled |  |
| Other, including length of time trialled |  |
| Secondary Care investigations and findings | Pelvic examination (date and results): |
| Ultrasound scan / Transvaginal ultrasound scan (date and results): |
| Hysteroscopy (date and results): |
| Other: |
| Treatment options discussed (please tick all that apply) | ⍻ Pharmaceutical⍻ Oral⍻ Progestogen IUS | ⍻ Surgical ⍻ Myomectomy⍻ Hysterectomy | ⍻ Ablation⍻ Uterine Artery Embolisation ⍻ Other |
| Please give details of other: |
| Reason for chosen treatment pathway |  |

**Declaration**

I confirm that the information provided within this form is accurate to the best of my knowledge.

I certify that the patient named on page 1 of this form has given their permission for this information to be provided to Bupa for the purposes described within this form.

|  |  |
| --- | --- |
| **Signature:** | **GMC** **number**: |
| **Name** (please print): | **Date** **form** **completed:** |

I confirm that the following documents are being sent to Bupa with this form (please tick those that apply) Please note: items in bold are mandatory.

⍻ **GP referral**

⍻ Treatment plan

⍻ **Out-patient assessment letter**

Bupa funding is subject to the terms of the customer’s policy and pre-authorisation. You should advise your Bupa patients that if they are admitted to hospital without a written referral and pre-authorisation, their costs may not be covered by Bupa.

**Please return the completed form to Bupa by fax to 01619 31 50 80**

Please do not use email to send patient-identifiable data as it is not necessarily a secure method of communication.