Funding request form: Extension to in-patient Addiction Treatment Programme

Please complete this form to check whether the Bupa patient's policy covers an extension to their in-patient treatment programme for addiction.

We consider the strength and quality of the evidence of clinical effectiveness, clinical appropriateness and the anticipated measurable outcomes to see whether treatment is covered. We fund treatment that's covered by the patient's policy and is in line with published evidence-based guidelines, which we use along with outcome measures AUDIT, SADQ, LDQ, APQ.

Please complete each section of this form, as it captures all the information we need to see whether the proposed treatment is covered by the patient's health insurance.

We're unable to agree funding based on incomplete forms or evidence, and we'll need to ask for more information which is likely to delay our funding decision and the patient's treatment.

Please return this form to us by secure email to mentalhealthrequests@bupa.com. Information you send us by email isn't usually secure until it reaches us. We use secure email provided by Egress Switch. You can sign up for a free account at https://switch.egress.com/ui/learn. You won't be charged to send secure emails to a Bupa email address using this service.

If you've any questions, please call us on **0345 600 5446**. We're here between 8am to 8pm Monday to Friday and 8am to 4pm on Saturday (we may record or monitor our calls).

We'll let you know whether the proposed treatment is covered by phone or email within two working days of receiving your completed form.

PATIENT'S DETAILS

Patient's name:

Date of birth: Bupa Membership Number:

CLINICIAN'S DETAILS

Name of admitting consultant:

Hospital name: Phone number:

Bupa Provider Number:

Did the admitting consultant complete this form? ☐ Yes

☐ No, please give name of person completing form:

ADMISSION DETAILS

Admission date: Number of nights' overnight leave taken during stay:

Proposed continued treatment from: to:

DIAGNOSTIC INFORMATION

If there's been a change in diagnosis since the patient's first admission, please state new diagnosis with International Classification of Diseases (ICD) code and all relevant co-morbidities (where applicable):

FUNDING REQUEST FORM: EXTENSION TO IN-PATIENT ADDICTION TREATMENT PROGRAMME

Please describe the patient's progress during this hospital admission in relation to the anticipated outcomes stated on the admissions form (please give specific outcome measures):

REASON(S) FOR EXTENSION TO IN-PATIENT CARE

Please explain the reason(s) for extending in-patient care rather than other treatment alternatives (such as out-patient treatment or day-care to enable discharge and recovery):

Who is requesting extended in-patient treatment care?

☐ Consultant ☐ Patient ☐ Patient's family/carer ☐ Patient's GP

RISK ASSESSMENT

Please indicate the level of risk identified in each category when the patient was assessed.

Risk	Level of risk			
	None	Low	Moderate*	Severe*
Suicide/self harm	☐	☐	☐	☐
Neglect	☐	☐	☐	☐
Violence/Harm to others	☐	☐	☐	☐
Other, give details	☐	☐	☐	☐

***If a risk is identified as moderate or severe, please complete the risk assessment section on the final page or send a copy of your hospital/clinic's risk assessment with this form.**

Is the patient likely to be detained under the Mental Health Act (MHA)?

☐ Yes (please give details): ☐ No

TREATMENT

Please describe any changes to the previously plan and explain the future treatment plan. Please also give details of plans in place to minimise or remove risk:

Current treatment(s):

Current level of observation:

Goals of treatment and anticipated outcome of treatment:

Please estimate length of stay needed to complete the in-patient treatment plan:

Are discharge plans in place? If so, please outline:

DECLARATION

Please sign to confirm that the information on this form is accurate, that you've obtained informed consent from the patient, and have explained to the patient that their care is subject to the terms of their policy and may not be covered if they're admitted to hospital without a written referral and pre-authorisation.

Signed: Date:

GMC Number

FUNDING REQUEST FORM: EXTENSION TO IN-PATIENT ADDICTION TREATMENT PROGRAMME

RISK ASSESSMENT (Please complete if not enclosing a copy of your hospital/clinic's assessment)

RISK INDICATOR SUMMARY – SUICIDE/SELF HARM

Risk indicator	Yes	No	N/A	Risk indicator	Yes	No	N/A
Helplessness/hopelessness	◯	◯	◯	High level of distress	◯	◯	◯
Suicidal ideation	◯	◯	◯	Family history of suicide	◯	◯	◯
Planned intent	◯	◯	◯	Divorced/widowed etc	◯	◯	◯
Previous attempts on life	◯	◯	◯	Unemployed/retired	◯	◯	◯
Alcohol/drug misuse	◯	◯	◯	Recent major life event	◯	◯	◯
Previous history of violence	◯	◯	◯	Major illness/disability	◯	◯	◯
Believe no control over life	◯	◯	◯	Other (please give details below)	◯	◯	◯
Comments:							

RISK INDICATOR SUMMARY – VIOLENCE/HARM TO OTHERS

Risk indicator	Yes	No	N/A	Risk indicator	Yes	No	N/A
Expressed intent to harm others	◯	◯	◯	Violent paranoid delusions	◯	◯	◯
Previous violent acts/incidents	◯	◯	◯	Command hallucinations (violent)	◯	◯	◯
Misuse of drugs/alcohol	◯	◯	◯	Inappropriate behaviour (sexual)	◯	◯	◯
Signs of anger/frustration	◯	◯	◯	Inappropriate behaviour (other)	◯	◯	◯
Known personal trigger factors	◯	◯	◯	Other (please give details below)	◯	◯	◯
Comments:							

RISK INDICATOR SUMMARY – NEGLECT

Risk indicator	Yes	No	N/A	Risk indicator	Yes	No	N/A
Previous history of neglect	◯	◯	◯	Unable to shop for self	◯	◯	◯
Failing to eat/drink properly	◯	◯	◯	Difficulty maintaining hygiene	◯	◯	◯
Inadequate housing/amenities	◯	◯	◯	Difficulty with physical health	◯	◯	◯
Financial difficulties	◯	◯	◯	Difficulty communicating needs	◯	◯	◯
Lack of positive social contacts	◯	◯	◯	Other (please give details below)	◯	◯	◯
Comments:							

RISK INDICATOR SUMMARY – OTHER

Risk indicator	Yes	No	N/A	Risk indicator	Yes	No	N/A
Self harm/injury	◯	◯	◯	Cultural isolation	◯	◯	◯
Abuse by others (physical/sexual)	◯	◯	◯	Non-violent sexual offence	◯	◯	◯
Abuse of others	◯	◯	◯	Arson/damage to property	◯	◯	◯
Exploitation by others	◯	◯	◯	Harassment	◯	◯	◯
Exploitation of others	◯	◯	◯	Other (please give details below)	◯	◯	◯
Comments:							

Please give details of opportunities for risk prevention/protective factors: