In-patient mental health care admission

Funding request form

Please complete this form and return it to us to check whether your Bupa patient's policy covers a proposed in-patient stay for mental health care. You'll need to send it to us when you assess your patient and not after they're admitted to hospital, so we can let them know whether their care is covered by their policy.

Our healthcare schemes may cover in-patient treatment for mental health. Where they do, the cover is in line with published evidence-based guidelines and outcome measures such as PHQ9, GAD7, BECKS.

Please complete each section of this form, unless advised otherwise, as it captures all the information we need to see whether the proposed treatment is covered by the patient's health scheme. Incomplete forms or information are likely to delay our funding decision and your patient's treatment.

Please return this form and a copy of the GP referral to us by secure email^ to mentalhealthrequests@bupa.com

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

^Please be aware that information you send to this email address may not be secure unless you send us your email through Egress. For more information and to sign up for a free Egress account, go to **https://switch.egress.com**. You won't be charged for sending secure emails to a Bupa email address using the Egress service.

Patient's details

Title (please tick)	☐ Miss ☐ Mrs ☐ Ms ☐ Mr ☐ Dr ☐ Other (please state)
Patient's name	
Date of birth	D D M M Y Y Y Y
Bupa membership number	

Clinician's details

Name of admitting consultant
Bupa provider number
Hospital name
Hospital's Bupa provider number
Name of person completing this form if different to above
Phone number

Diagnosis and presenting symptoms

Please give details of the patient's diagnosis or working diagnosis, their presenting symptoms and the date of onset for all conditions being treated now (please include ICD codes):

Please provide details of the patient's mental health history:

Risk assessment

Date of assessment D D M M Y Y Y Y

Does the patient currently present a risk to: ☐ Themselves ☐ Others

Has the Mental Health Act been considered? ☐ Yes ☐ No

If yes, please give details

Have you formulated the risk based on outcome measures? ☐ Yes ☐ No

If yes, which tool did you use?

Please tick all appropriate risks

Self harm ☐ Suicidal thoughts/plans ☐ Violence ☐ Serious self neglect ☐ Exploitation ☐ Vulnerability ☐

Risk assessment (continued)

Are there any Safeguarding concerns or alerts for the patient or others? ☐ Yes ☐ No

If yes, please explain:

What level of nursing observations is prescribed?

If the patient requires one-to-one nursing level observations, please let us know the date and time these started and the date and time they'll be reviewed:

What day is the ward round?

Previous treatments

What other interventions or treatments have been tried before this request for admission?
Please select all those that apply and give details of the type, duration and rationale for the treatment

☐ Psychological (please explain)

☐ Pharmacological (please explain)

☐ Other (please explain)

☐ None. Please give details of the treatments tried to date and the response to them

Please include details of any treatment history and duration for this or related condition/s provided by the NHS, health insurance or self-funded care. Please include both psychological and pharmacological treatment.

About the proposed treatment

Date of consultation D D M M Y Y Y Y

Proposed admission date D D M M Y Y Y Y

Expected date of discharge D D M M Y Y Y Y

Please describe the in-patient treatment plan (including any short-term and long-term outcomes) to enable discharge and recovery. Please also provide details of plans in place to minimise risk:

Are there discharge plans in place? ☐ Yes ☐ No. If so, please outline:

Please give the reason for recommending in-patient care instead of other treatment alternatives (such as out-patient treatment or day-care to enable discharge and recovery):

Who is requesting the treatment?

- ☐ Consultant
- ☐ Patient
- ☐ Family/Carer
- ☐ GP

Does the patient agree with the treatment plan? ☐ Yes ☐ No

Consultant's declaration

I understand that the clinical information I've supplied may be considered to be a medical report for insurance purposes. I confirm that my patient (or their legal representative) has given their permission for me to share this information and, where they've asked to review this information, they've been given an opportunity to do so before I submitted this form.

Consultant's name

General Medical Council number

Date D D M M Y Y Y Y