Extension of in-patient stay

Funding request form

Please complete this form to check whether the proposed extended in-patient stay is covered by the Bupa patient's healthcare scheme. There's no need to complete it if your hospital has agreed a package price with us.

Please complete all sections of this form. Without all the information, our response to your funding request may be delayed.

Return the completed form to us by email to: **caresupportteam@bupa.com** or via Healthcode. If you need to send us sensitive information you can email us securely using Egress^.

We'll let you know by email within a working day of receiving the completed form whether cover is available.

If you've any questions, please call: **0345 755 3333* (option 2)**. We're here between 8am and 6pm Monday to Friday and happy to help.

1. Patient's information

Title (please tick) ☐ Miss ☐ Mrs ☐ Ms ☐ Mx ☐ Mr ☐ Dr ☐ Prof ☐ Other (please state)

Patient's name

Date of birth D D M M Y Y Y Y

Bupa membership number

Patient contact number

Hospital information

Hospital name

Bupa provider number

Hospital contact name

Hospital contact number

Responsible (lead) consultant (name)

2. Admission information

Admission date and time

Pre-authorisation number

Has patient already been discharged (☐ Yes / ☐ No)

If yes, please provide the discharge date and time:

Extension from | Extension to

* We may record or monitor our calls.

^ 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.

3. About the patient's condition and proposed treatment plan

What is the diagnosis?

Does the patient have any comorbidities? If yes, please list them:

Please provide the clinical rationale for an extension and a detailed treatment plan below (including changes in the patient's condition, additional procedures/interventions etc):

Please give details of clinical interventions carried out and results to support the request (including blood results, scans etc):

4. Details of previous and proposed future procedures (where applicable)

Previous procedure(s)

Has the patient had any procedures during the current in-patient stay?

☐ Yes ☐ No

If yes, please give details:

Procedure code(s)

Surgeon's name(s)

Anaesthetist's name(s)

Proposed procedure(s)

Are any procedures planned for the patient?

☐ Yes ☐ No

If yes, please give details:

Procedure code(s)

Surgeon's name(s)

Anaesthetist's name(s)

Please give details of any additional specialist treatment or input (for example medication, speech therapy, SALT assessment or outcome of MDT discussions):

Please give details of any second opinion review(s) carried out:

5. Details of therapies tried (where applicable)

Therapy	Name of medication	Frequency	Review/ end date
Will the patient need IV antibiotics? ☐ Yes ☐ No If yes, please give details			
Will the patient need IV fluids? ☐ Yes ☐ No If yes, please give details			
Will the patient need IV pain relief? ☐ Yes ☐ No If yes, please give details			
Will the patient need additional drugs? ☐ Yes ☐ No If yes, please give details			
Will the patient need parenteral feeding? ☐ Yes ☐ No If yes, please give details • Nasojejunal • Nasogastric • Intravenous			

Therapy	Name of medication	Frequency	Review/ end date
Will the patient need physiotherapy? ☐ Yes ☐ No If yes, please give details			
Will the patient need occupational therapy? ☐ Yes ☐ No If yes, please give details			
Will the patient need speech and language therapy assessment? ☐ Yes ☐ No If yes, please give details			

Has an MDT meeting been held?

☐ Yes ☐ No

If yes, please attach notes including: meeting location, date; list of attendees (names and specialties/profession), and the outcome of the meeting

6. Discharge information

Expected discharge date and time

Planned discharge destination

Is this a complex discharge?

☐ Yes ☐ No

If yes, please give details:

Please provide details about discharge arrangements (including any care arrangements prior to the admission, community referrals being put in place, equipment, support or social care package requirements):

If any of the details on the discharge plan above are incomplete please explain:

Palliative and end of life care

Has the patient ever been referred for palliative care?

☐ Yes ☐ No

If yes, please complete the section below:

Is the patient receiving palliative care?

☐ Yes ☐ No

Is the patient receiving end of life care?

☐ Yes ☐ No

Has there been an advanced care discussion with patient or next of kin?

☐ Yes ☐ No

If yes, please give the names of those involved in the discussion and their relationship to the patient:

Please give details of the decisions made by the people named above:

Is there a do not attempt resuscitation (DNAR) order in place?

☐ Yes ☐ No

Has the patient's preferred place of death been discussed?

☐ Yes ☐ No

If yes, please give details:

7. Clinician's declaration

Please ask the doctor in charge of the patient's care or a lead nurse to complete the section below.

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.

Doctor's / nurse's name:

Job title

General Medical Council / Nurse NMC (Nursing and Midwifery Council) PIN number:

Date D D M M Y Y Y Y

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