Funding request form: In-patient Addiction Treatment Programme

Please complete this form to check whether the Bupa patient's policy covers an in-patient treatment programme for addiction. We need this form at the point you assess the patient, rather than once they are admitted so we can let them know whether their care is covered by their policy. If not, they'll be responsible for the cost of their stay.

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 also need a full risk assessment to confirm cover, in line with NICE Clinical guidelines CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, and CG52 Drug misuse in over 16s: opioid detoxification.

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. Please include supporting information, where appropriate, so we can understand the relationship between the treatment plan, level of risk and the level of care being requested.

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:

Home address:

Date of birth: Bupa Membership Number:

GP's name
and address

CLINICIAN'S DETAILS

Name of admitting consultant:

Hospital name: Ward name / number:

Phone number: Email address:

Bupa Provider Number:

Did the admitting consultant complete this form? ☐ Yes

☐ No, please give name of person completing form:

FUNDING REQUEST FORM: IN-PATIENT ADDICTION TREATMENT PROGRAMME

PRESENTING SYMPTOMS

Current daily units / Intake

Background / History of presenting condition:

Past medical history and relavent medication details

Please tick relevant presenting symptoms below

☐ Tremors	☐ Sweating	☐ Nausea
☐ Visual hallucination	☐ Auditory hallucination	☐ Seizures
☐ Depression	☐ Anxiety	☐ Irritability
☐ Aggression/ violence	☐ Restlessness	☐ Memory Loss
☐ Insomnia	☐ Pins and Needles	☐ Blackouts Intoxicated injuries
☐ Incontinence	☐ Cough up blood	☐ Ascites

ADMISSION DETAILS

Proposed admission date: Date form completed

Estimated length of stay:

Reason for admission:

Primary diagnosis:

International Classification of Diseases (ICD) code

Secondary diagnoses:

Has an assessment tool (e.g SADQ/ AUDIT/DAST) been used?

☐ Yes, please give details of the tool used and the score below.

☐ No, please explain why not below.

PREVIOUS TREATMENT

Has there been any previous treatment or any attempts to reduce intake? ☐ Yes, please give details below. ☐ No, please move on to the next section.

Please tick type of treatment	Please tick type of support	Date	Outcome and details of keyworker
☐ Reduction ☐ Detox ☐ Addiction Treatment Programme	☐ NHS/AA ☐ Self ☐ Online ☐ Other		

FUNDING REQUEST FORM: IN-PATIENT ADDICTION TREATMENT PROGRAMME

CLINICAL APPROPRIATENESS OF IN-PATIENT TREATMENT FOR ADDICTION TREATMENT

Please give the clinical rationale for in-patient treatment and why this couldn't be offered in a community out-patient or day-case setting.

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.**

Has a full risk assessment been completed? ☐ Yes please send a copy with this form ☐ No

SAFEGUARDING OTHERS

Are there any dependents who will be affected by an in-patient admission? ☐ Yes, please give details below. ☐ No, please move on to the next section.

TREATMENT PLANNING

Summary of proposed treatment plan including any discharge arrangements:

CONSULTANT'S 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:

GMC number:

FOR BUPA USE ONLY

☐ Form indicates evidence of immediate and high risk of significant harm to patient	☐ Form indicates evidence of immediate and high risk of harm to dependents/family/others	☐ Form indicates evidence of high risk of serious medical complication associated with withdrawal due to severity of addiction	☐ Form indicates combination of risk factors resulting in severe risk which requires inpatient admission and cannot be considered for day-case or out-patient treatment

FUNDING REQUEST FORM: 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: