Irish Life health

Health in The Home Referral Form

TCP Homecare

Policyholder details

Title: First name: Surname:

Address:

Date of birth (dd/mm/yy): Mobile Tel. No.: Home No. or Email:

Hospital No: Ward: Bed No:

Diagnosis:

Allergies: Weight:

Reason for Referral: (1)

Reason for Referral: (2)

Consultant details

Title: First name: Surname:

Hospital: Speciality:

Contact details:

Medication and Administration

No.	Medication	Calculated Dose	Route	Frequency	Duration of Infusion (Mins)	Anticipated Start Date & Dose	End Date & Dose
1							
2							
3							

Negative Pressure Dressing Type	Frequency of Dressing		Foam Size	Foam Type	Pump No. and Pressure	Pump Action	Dressing Plan
Vac ☐	Once week ☐	☐	Small ☐	Black ☐	No.:	Continuous ☐	
Renesys ☐	Twice week ☐	☐	Medium ☐	White ☐		Intermediate ☐	
Pico ☐	Three times per week ☐	Other ☐	Large ☐	Silver ☐	mhg:		

I authorise the consultant/doctor referred to in this form to furnish TCP Homecare (being Temperature Controlled Pharmaceuticals Limited) with this form and its contents. I acknowledge that TCP Homecare is collecting the information in this form as an agent of Irish Life Health and I agree to the disclosure by TCP Homecare of this form and its contents to Irish Life Health. I also agree that Irish Life Health may use the information in this form to assess whether my applicable policy with Irish Life Health entitles me to participate in treatment in the home in respect of the particular medication, administration and any other aspect of care stated in this form, whether I am eligible for such treatment and to determine whether to engage TCP Homecare to provide such treatment to me.

Print patient name in block capitals:	Patient Signature:	Date(dd/mm/yy):

Administration:	To be administered by a TCP Homecare Nurse in accordance with the SmPc

Emergency Medication Requirements

The medications listed below will only be administered to treat an infusion related reaction.

Medication	Dose	Route
Epinephrine (Adrenaline)	500mcg	IM PRN x 2 (10-1 5min apart for more severe reactions)
Chlopheniramine	10mg	10-20mg IM or slow IV over 1 min PRN x 1 for severe reaction
Hydrocortisone	200mg	IV PRN x 1 for severe reaction
Prescriber Signature:	Bleep No:	Date(dd/mm/yy):

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Specimens Required

Monday	Tuesday	Wednesday	Thursday	Friday

Type of bloods required

Most Recent Bloods: (or attach separately)

Clinical Observations on date of referral:

B/P:	HR	Temp:	RR:	SaO_2

Liaison Nurse:	Liaison Nurse Contact details:

GP Name:	GP Address:
GP Contact Ph. No.:	

Next of Kin Name:	Next of Kin Contact details:
Next of Kin Relationship:	

Investigations completed in hospital:

Any other information in relation to treatment within the home:

Please confirm that the patient has had a minimum of ONE Infusion within the hospital setting ☐ Yes ☐ No

Past History:

Current Medications:

Does the patient have a line insitu? ☐ Yes ☐ No

Type of line:	I confirm that the line has been reviewed and is safe for use at home Please tick ☐	I also confirm that a date will be confirmed with Next of Kin for removal of CVAD post treatment completion date Please Tick ☐	Date Inserted (dd/mm/yy):

Referring Doctor’s Signature:	Date (dd/mm/yy):

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Irish Life health

Health in the Home Declaration

TCP Homecare

Consent

I declare that at the time I underwent medical treatment I was a party to a health insurance contract and was entitled to treatment under my Irish Life Health plan. I declare that my consultant recommended the treatment and referred me to the appropriate Health in the Home provider for further treatment. I declare that to the best of my knowledge, the information provided in Part 1 of this form is accurate, true and complete. I authorise the doctors/consultant/physiotherapist/hospital to furnish Irish Life Health, or any authorised agent it may appoint to act on its behalf, with any information requested, including access to my doctors, consultant or hospital records, where this is necessary in relation to any claim regarding treatment or services received by me or my named dependants. I authorise the direct payment by Irish Life Health to the Health in the Home provider as appropriate for the services set out on this claim form to the extent provided for under my Irish Life Health plan. I verify the details of the accounts submitted on my behalf by the Health in the Home provider as an accurate reflection of the treatment I received. I understand that the details of these amounts will be included in my Irish Life Health statement of payment and I will have the opportunity to contact Irish Life Health directly with any queries. Charges not covered under the Irish Life Health plan to which I subscribe will remain my responsibility or that of the named dependant who received the treatment to settle directly with the Health in the Home provider. In consideration of Irish Life Health discharging my medical expenses to the extent of cover limits, I undertake to Irish Life Health to include these expenses as part of my claim against a third party and to inform my solicitor or Personal Injury Assessment Board to this effect when pursuing any claim.

Data Protection

Irish Life Health dac is registered with the Office of the Data Protection Commissioner to act as a data controller and data processor in relation to the personal information held about you and any other member named on your policy.

The personal information that you have provided to us or that we otherwise obtain in connection with your policy will be used to administer your policy and other insurance products provided by us, other companies in the Irish Life Group or other commercial partners, in accordance with data protection and other applicable legislation and the Office of the Data Protection Commissioner-approved Code of Practice on Data Protection for the Insurance Sector. Please do not send us any genetic test results.

We will share this information with our third party administrators and any other commercial entity for the purposes above and as required to provide our services and in order to comply with legal obligations imposed on us. We may share and use this information both inside and outside of the European Economic Area, in confidence, for these purposes. We may in certain circumstances either directly or indirectly share your personal information with other insurers for the purposes of verifying information and determining waiting periods and with insurance bodies to the extent permitted by law. If you give us false information or fail to disclose information, we will record this.

To help improve the level of service we provide, we may on occasions contact you for participation in consumer satisfaction or research surveys. Your details may be used for these purposes for 12 months after your policy has ceased.

Important: In certain instances, we may need to collect personal information, including medical or other sensitive personal information, from third parties about you and any other member named on your policy. This information will remain strictly confidential and will only be sought and used in order to provide the services set out in your contract with us and for administration of this policy. By entering into a new policy with us, or renewing or amending an existing policy with us, you are also confirming that where relevant, each member of the policy has reviewed this notice and given their consent for the disclosure to us and the use of their personal information (including information collected from third parties) in the manner and for the purposes set out in this notice.

We may record your telephone conversations with us for training, verification and compliance purposes.

You and other members named on your policy (as applicable) have a right (subject to applicable data protection legislation) to obtain a copy of the personal information we hold about you and/or them (as applicable). In order to obtain a copy of such information, please write to: Irish Life Health Irish Life Health PO Box 13028, Dublin 1.

Should you discover any errors or omissions in the personal information held by us, you or as applicable, the other members named on your policy may have the right to have such errors corrected, blocked or erased, free of charge, so please contact us by writing to us at: Irish Life Health PO Box 13028, Dublin 1.

This notice should be read in conjunction with our Privacy Statement at www.irishlifehealth.ie which sets out more detail of how we use your personal information and the personal information of other members on your policy.

We would like to contact you to give you information and marketing materials about other products and services offered by us or other companies within the Irish Life Group. For this purpose we may pass your information to other companies within the Irish Life Group. We may use your details for this purpose for up to 12 months after your policy has ended. You might hear from us via landline, mobile, post, email or SMS. Would you like to receive this information? ☐ Yes ☐ No

Declaration

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Irish Life Health Privacy Notice which can be found at **http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/**

Print name in block capitals:

Signature: Date: (dd/mm/yy)

Irish Life Health, PO Box 13028, Dublin 1
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