Irish Life health

ICU/HDU/CCU/SCBU Claim Form

This form should be completed by the Consultant who provides Intensive Care Medicine in accordance with the rules outlined in Irish Life Health's Schele of Benefits. This form should be completed in full and accompany the Hospital Claim Form.

Patient Details (To be completed by Consultant)

Patient name									
Irish Life Health Membership Number									
Date of birth									
Admission type	ICU	◯	HDU	◯	CCU	◯	NICU	◯	SCBU	◯

Hospital Details

Name of hospital									
ICU admission Date and Time	Date						Time		
ICU discharge date and time	Date						Time		

Source of Referral

Source of referral (please tick)	A&E	◯	Theatre	◯	Ward	◯	Transferred from another hospital	◯	
Please provide referral details/name									

Treatment Details

Please confirm clinical indications which warranted admission to ICU/HDU/CCU/NICU/SCBU:

Please indicate all relevant treatment(s) provided: (Please tick)

Invasive Mechanical Ventilation	◯	Please specify							
Non-invasive Mechanical Ventilation	◯	Please specify							
ICU admission Date and Time	Date						Time		
ICU discharge date and time	Date						Time		

Irish Life health

Print Clear

Invasive haemodynamic monitoring	◯	Please specify	
Dialysis	◯	Please specify	
Post-operative observation	◯	Please specify	
Surgical drain(s)	◯	Please specify	
Pain management	◯	Please specify	
ECMO/VAD/IABP	◯	Please specify	
Telemetry	◯	Please specify	
Inotropes/vasopressors	◯	Please specify	
Invasive neurological monitoring	◯	Please specify	
Other	◯	Please specify	

Please include details of medical management i.e. intravenous fluids, antibiotics, TPN, etc.

Discharge Status (Please tick)

Transferred to ward in same hospital	◯
Transferred to ward in different hospital	◯
Transferred to ICU in different hospital	◯
Deceased	◯
Discharged home / Convalescence / Nursing home / Rehabilitation unit	◯

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/

Signature (member)	
Date:	
Irish Life Health Doctor Code	