Hospital Intensive Care Medicine

Claim Form (Supplementary)

For Office Use Only	Claim No.	Tran. No.	Ass. No.	Hosp. Code.

This form is for completion by the consultant who provides intensive care medicine in accordance with the Vhi Intensive Care Medicine Ground Rules contained in the Vhi Schedule of Benefits for Professional Fees. **Please ensure that this form is attached to the patient's Vhi Claim Form.**

Section 1: Patient Details - to be completed by attending consultant

Subscriber's Name and Address (BLOCK LETTERS)

PATIENT DETAILS

Patient's Name: _____

Patient's Date of Birth: D D M M Y Y

Please quote the patient's Membership no. here:

Section 2: Hospital details - please fully complete this section

Name of Hospital:	Date of Admission to Hospital:
Date of Admission to ICU:	Time of Admission to ICU:
Date of Discharge from ICU:	Time of Discharge from ICU:
Number of ICU beds in unit:	ICU unit name/number:

Section 3: Source of Referral

Ward: ☐ Theatre: ☐ Accident & Emergency Dept.: ☐ Another Hospital: ☐ (Please tick)

Name of other hospital: _____

Other, describe: _____

If Theatre, please give details of the procedure(s) performed: _____

APACHE Score (Acute Physiology and Chronic Health Evaluation): _____

Initiation of Mechanical Ventilation Support

Date of Commencement	Time of Commencement	Date of Cessation	Time of Cessation	Initiated By	Patient Location (Please tick) ICU ☐ Theatre ☐

Section 4: History

By whom was the patient referred to you?

Title: _____ First Name: _____ Surname: _____

Nature of symptoms: _____

How long had the symptoms been present?

Months _____ Weeks _____ Days _____ Other _____

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Section 5: Diagnosis

Final Diagnosis: _____

_____

(a) Primary: _____

_____

(b) Secondary, if any. List all: _____

_____

Section 6: Treatment

Full Details of ICU Treatment: _____

_____

_____

Please include details of procedures and medical management: _____

_____

_____

Please supply full details of the reason(s) for maintenance of the patient on mechanical ventilation support for any period in excess of 36 hours in the case of planned post-operative intensive care:

_____

_____

Section 7: Outcome Status - please tick appropriate box

To where was the patient discharged:

Transfer to ICU in another Hospital: ☐ Date: D D M M Y Y

Transfer to Convalescent Home: ☐ Date: D D M M Y Y

Ward in same hospital: ☐ Date: D D M M Y Y

Transfer to Ward in another Hospital: ☐ Date: D D M M Y Y

Deceased: ☐ Date: D D M M Y Y

Section 8: Certification

Data Protection:

The personal data provided in this claim form will be processed in accordance with our Data Protection Statement and the requirements of the Data Protection Acts 1988 and 2003.

I hereby certify that the treatment specified was necessitated by the illness described by me above, and that the stay in ICU was justified by the patient's medical condition.

X Consultant's Signature
(You must sign here)

_____

Vhi Doctor Code:

Date: D D M M Y Y

Address:

Vhi Insurance DAC trading as Vhi Insurance is regulated by the Central Bank of Ireland.

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QUALITY ISO 9001:2008 NSAI Certified

Tel: **(056) 4 444 444** *or* **1890 44 44 44**. Lines open 8am-6pm Monday to Friday and 9am-3pm Saturday.

Contact: **Vhi.ie**
Vhi.ie/contact

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