

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 Schedule 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		:	

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.

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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 <https://www.irishlife.ie/health-insurance/privacy-and-legal/data-privacy-notice/>

Signature (member)								
Date:								
Irish Life Health Doctor Code								