



**Proposed treatments**

Please describe the clinical interventions and treatment that are still to be undertaken or concluded as part of your extension of stay request.

**Reason(s) this cannot be delivered as an out-patient**

Please detail clinical reason(s) why this treatment cannot be conducted as an out-patient. Please note that convenience of administering treatment cannot be the sole criteria for continued inpatient stay.

**Risk Assessment & Management**

Please detail the risk factors that mean this member is unable to be safely treated as an outpatient.

Please define nursing observation level

**Discharge plan**  
Please detail the anticipated follow up outpatient requirements

**Funding note**  
If this patient's treatment needs exceed the financial limit of their policy an alternative treatment path will be required. Please indicate that you are aware of this possibility and are prepared to act to secure continuation of care.

Information on this form will be reviewed by Cigna Mental Health Services to monitor its Mental Health Programme. Further information may be requested.  
Submission of this form does not constitute authorisation of the treatment requested until approved by Cigna.

Name	
Date	
Signature of identified consultant	

**Together, all the way.<sup>SM</sup>**



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