MENTAL HEALTH PROGRAMME:
INPATIENT TREATMENT EXTENSION REQUEST

Please note - complete form in BLOCK CAPITALS
Please return this form to **mhnurses@cigna.com**

Hospital name	
Telephone number	

PATIENT DETAILS	
Name	
Member number	
Address	
Postcode	
Date of birth	
Admission date	

IDENTIFIED CONSULTANT	
Name	

Diagnosis				
DSM V Code				
Is this a change from the original admitting diagnosis	Yes:		No:	
Number of additional days being requested				
Proposed discharge date				

ADMISSION EXTENSION DETAILS
Progress & recovery achieved since admission Please detail the clinical change that has been achieved since the patient began inpatient stay.

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.[SM]

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