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For attention: The treating Consultant

Dear Dr

Re: Critical Illness Protocol (CIP) Application

PATIENT NAME	
DATE OF BIRTH	

Medmark provides the Occupational Health Service (OHS) to the Department of Education and Skills. We are required to provide, as part of this service, opinions with regards to employees' eligibility for benefits under the Critical Illness Protocol as referred to in the Department of Education and Skills' Standard Operating Procedures Manual: A Manual for Boards of Management/Managers & ETB's. In order to process applications the following is required:

- The employee is required to furnish the OHS with a doctor-to-doctor report from his/her treating consultant. The unique critical illness referral number must be furnished with this report. The treating consultant's specialism must be appropriate to the critical illness for which the employee is making a claim. It is essential that the medical evidence submitted is comprehensive and includes all relevant clinical details. It must address diagnosis, treatment and prognosis.
- The cost of compilation of all such reports is the responsibility of the employee.

You are kindly requested to provide the information related to the above named patient as indicated on the next page.

Please be assured that your report will be dealt with in the strictest of confidence and serves only to assist us in the decision with regards to eligibility for the above benefits.

Please forward your completed report to:

Dr Jacques Bronkhorst
Medmark Occupational HealthCare
28 Penrose Wharf
Penrose Quay
Cork

Yours sincerely,

Medmark Occupational Healthcare

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REPORT FROM TREATING CONSULTANT: CRITICAL ILLNESS PROTOCOL (CIP) APPLICATION

– Form No. MM180

PATIENT NAME	
DATE OF BIRTH	
CONSULTANT NAME	
CONSULTANT'S SPECIALITY	
CRITICAL ILLNESS REFERRAL NUMBER	CIPR-

Exact diagnosis:

____

____

Date of diagnosis: ____

Treatment received to date: ____

____

____

____

____

Results of histology (if applicable): ____

Staging of disease (if applicable):____

If applicable: date(s) of hospital admission ________________**and discharge** __________________

If applicable: Name of hospital: ____

Long term prognosis:

____

____

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Anticipated recovery time for the condition: ____

Presence of any additional medical conditions: ____

____

____

____

Presence of medical complications: ____

____

Other relevant information:____

____

____

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___________________________ ______________________

CONSULTANT SIGNATURE **DATE**

CONSULTANT STAMP