Australian Health Service Alliance

PSYCHIATRIC OVERNIGHT & PSYCHIATRIC DAY APPROVED PROGRAM CERTIFICATE

Certificate Must Be Completed For <u>Every Claim</u>

Hospital Name: _____
(Please Print)

(Section 1) - Particulars of Patient and Hospital (may be completed by Hospital Staff)

Membership No: ☐☐☐☐☐☐☐☐

Patient Name _____

Date of Admission to Psychiatric Program: _____ Anticipated LOS _____ Date of Discharge _____

Was patient admitted from another hospital? ☐ No ☐ Yes (Please Specify) _____

Name/Code of Psychiatric Program _____ Name of treating Psychiatrist _____

(Section 2) - Certificate of Patient Condition

Admission Diagnosis (as per Current Classification)

- ☐ Schizophrenic Disorder
- ☐ Major Depressive Episode
- ☐ Major Mixed Episode
- ☐ Major Manic Episode
- ☐ Personality Disorder
- ☐ Substance Use Disorders
- ☐ Organic Brain Disorder
- ☐ Somatoform Disorders
- ☐ Anxiety Disorders
- ☐ Other Psychotic Disorders
- ☐ Psychosis Disorder
- ☐ Bi-Polar Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Eating Disorder-Anorexia Nervosa
- ☐ Eating Disorder-Bulimia Nervosa
- ☐ Other Diagnosis **(Please Specify)** _____

Other Complicating Factors: (Please Specify) _____

Treatment Required

- ☐ Psychotherapy
- ☐ Psychotherapy Group
- ☐ Psychotherapy Other
- ☐ Living Skills
- ☐ Diversional
- ☐ Detoxification
- ☐ E.C.T.
- ☐ Pharmacotherapy
- ☐ 1/1 Counselling
- ☐ Other **(Specify details below)** _____

Next Treatment Phase

(Section 3) - Completion of Treatment/Discharge Status

- ☐ Home
- ☐ Nursing Home
- ☐ Community Care
- ☐ Refer to G.P.
- ☐ Day Program
- ☐ Another Hospital **(Specify)** _____
- ☐ Discharge at Own Risk
- ☐ Psychiatrist
- ☐ Other **(Specify)** _____

Discharge Diagnosis
(as recorded in discharge summary)

- ☐ Same as Admission
- ☐ Other (please specify) _____

Length of Stay (Days) _____ Number of patient Attendances _____

This certificate applies for the claim period from: _____ **To:** _____

Signature of Case Manager	**Name (Please Print)**	**Date**
_____	_____	_____