AHSA CORONARY CARE PATIENT CERTIFICATE – Hospital Name

***Section 1** – Patient And Hospital Details (may be completed by hospital staff)*

Admission to for Acute Cardiac Monitoring/CCU	***Discharge from Acute Cardiac Monitoring/CCU to:***	*UR No:* *Certif. No:*
☐ ***Elective*** ☐ ***Non-elective***	☐ ***Ward*** ☐ ***Home***	*Patient Name:*
☐ ***Transfer in (give details below)***	☐ ***Deceased*** ☐ ***Transfer out (give details)***	*Date of Birth:*
		Membership No:
Time _____AM/PM Date_____	*Time _____AM/PM Date_____*	*Fund Name:*

***Section 2** – Particulars of Admission (to be completed by Treating Cardiologist / Specialist)*

I certify that it was necessary for this patient to receive treatment in a coronary care unit and that the patient met the criteria for admission to this unit for the period shown.

*Procedure Performed (if applicable)*_____

*Reason for Acute Cardiac Monitoring:*_____

*Relevant Pre-existing Co-morbidities*_____

*Other Complicating Factors*_____

✸

☐ ***Myocardial Infarction*** ☐ ***Insertion of e Coronary Stents*** ☐ ***Coronary Angioplasty***

☐ ***Serious/Acute Ischaemic Heart Disease*** ☐ ***Complex Angiography***

☐ ***Heart Block*** ☐ ***Malignant Arrhythmias- type***

*Other*_____

If the patient is still in the unit at Day 7, what is the anticipated further LOS in CCU? days

Signature (of Treating Cardiologist/Specialist) *Name (please print)* *Date*

***Section 3** – Supporting Data for Admission*

Date (**Write at the top of each column) / **Day	***1***	***2***	***3***	***4***	***5***	***6***	***7***
Interventions (Please Tick each day)							
IV Antiplatelets/Anticoagulation(in conjunction with another intervention)							
IV Inotropes							
IV Vasodilators							
Femoral ArterialCatheter/							
IV Thrombolytic therapy							
Continuous IV Antiarrhythmics							
****Benefits only payable where conditions have been met(see above)***							
****ST segment monitoring***							
****Temporary Pacing/External Pacing/Temporary Wire***							

(New Certificate to be completed if stay exceeds 7 days, and every 7 days thereafter)

***Additional Comments/Information for further LOS in CCU, if required*:** _____

_____

_____

_____

Signature of Nursing Unit Manager ***Name (please print)*** ***Contact telephone number***