INTENSIVE CARE CERTIFICATE – AHSA

Hospital Name _____

NOT TO BE USED FOR ADMISSIONS TO CCU OR HDU

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

UR No: _____ *Certif. No:* _____

Admission to Unit

☐ ***Elective*** ☐ ***Non-elective***

☐ ***Transfer in (give details below)***

_____

Time _____*AM/PM* *Date*_____

Discharge from Unit to:

☐ ***Ward*** ☐ ***Home***

☐ ***Deceased*** ☐ ***Transfer out (give details)***

_____

Time _____*AM/PM**Date*

Patient Name: _____

Date of Birth: _____

Membership No: _____

Fund Name: _____

Section 2 – Particulars of Admission (to be completed by Treating Intensivist / Specialist)- must be completed for benefit assessment

I certify that it was necessary for this patient to receive treatment in an ICU and that the patient met the criteria for admission to this unit, i.e. nursing ratio and interventions, for the period shown.

*Major Reasons for admission and if applicable MBS of Surgical Procedures Performed)*_____

Pathophysiology (please tick relevant box/s)

☐ *Acute Cardiac Dysfunction* ☐ *Acute CVS Instability* ☐ *Acute Respiratory Dysfunction*

☐ *Acute Hepatic Dysfunction* ☐ *Acute Renal Dysfunction* ☐ *Acute Neurological Dysfunction*

☐ *Acute Severe Metabolic Disturbance* ☐ Major Trauma ☐ *Septic Shock* ☐ *Major surgery with complex post-operative need*

☐ *Obstetrics Emergencies* ☐ *Hypolvolaemic Shock* ☐ *Other*

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

_____ _____ _____

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

Section 3 – Supporting Data for Admission (may be completed by Intensive Care Registered Nurse)

Date *- (Write date at top of each column) /* ***Day***	***1***	***2***	***3***	***4***	***5***	***6***	***7***
Interventions **(Please Tick each day)**							
Nursing ratio 1:1 (required at least 12 hrs per day) –level 1							
Nursing Ratio 1:2 (required at least 12 hrs per day) –level 2							
Mechanical Ventilation or CPAP/BiPAP via tube							
Intubation time/date Extubation time/date							
Intra-Aortic Balloon Pump							
ICP Monitoring							
Extra Corporeal Support (ECMO)							
Invasive Monitoring to measure Cardiac Output (regardless of device used)							
Continuous Renal Replacement Therapy or Continuous Therapeutic Plasmaphoresis							
Level 1 rates for 1 or more interventions listed above plus 1:1 nursing							
IV Inotropes							
Major Blood Transfusion (over 2.5 Litres or 5 Units Packed RBCs)							
½ hourly Glasgow Coma Score (over 8 hours per day)							
Ventricular or Extra ventricular drain							
Arterial Catheter (when not part of cardiac output monitoring but includes an arterial catheter in any artery being used for continuous BP monitoring)							
Level 2 rates for 1 or more interventions listed above plus 1:2 nursing							
Temporary Pacing/External Pacing/Temporary Wire							
IV Vasodilators							
Continuous IV Antiarrhythmic Therapy							
Level 2 rates for 2 or more interventions listed above plus 1:2 nursing							
PRINCIPAL PATIENT CATEGORY *(level,1,2 - show each day)*							

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

***Additional Comment and/Information and likely reason for further LOS, if required*:** _____

_____

_____

_____ _____ _____

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