

<b>REHABILITATION PROGRAM CERTIFICATE HOSPITAL:</b>  Certificate No: <input type="checkbox"/> Inpatient <input type="checkbox"/> Day Patient <input type="checkbox"/> Outpatient/Sessional		Affix patient identification label here  UR no  Family name:  Given names:  Address  DOB: _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F																																				
Health Fund: _____		Fund M'Ship No _____																																				
<b>Sections 1-3 to be submitted with first and interim claims, with first claim no later than 21 days.</b> <b>Section 4 to be submitted at time of discharge or alteration to program or setting.</b>																																						
<b>Section 1: PRE-ADMISSION ASSESSMENT</b> Pre-admission assessment performed?: Yes/No If no, why? _____ <table style="width: 100%;"> <tr> <td style="width: 25%;">Patient Source:</td> <td style="width: 25%;"><input type="checkbox"/> Community</td> <td style="width: 25%;"><input type="checkbox"/> Acute Care Prog - This Hospital</td> <td style="width: 25%;"><input type="checkbox"/> Acute Care Prog - Another Hospital</td> </tr> <tr> <td colspan="4"><i>If another hospital ticked, please give name:</i> _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Consulting Rooms</td> <td><input type="checkbox"/> Hostel</td> <td><input type="checkbox"/> Nursing Home</td> </tr> <tr> <td>Patient assessed suitable for:</td> <td><input type="checkbox"/> Inpatient</td> <td><input type="checkbox"/> Day Patient</td> <td><input type="checkbox"/> Outpatient/ Sessional</td> </tr> <tr> <td colspan="4">Patient willingness and capacity to comply with program?: Yes/No</td> </tr> </table>				Patient Source:	<input type="checkbox"/> Community	<input type="checkbox"/> Acute Care Prog - This Hospital	<input type="checkbox"/> Acute Care Prog - Another Hospital	<i>If another hospital ticked, please give name:</i> _____					<input type="checkbox"/> Consulting Rooms	<input type="checkbox"/> Hostel	<input type="checkbox"/> Nursing Home	Patient assessed suitable for:	<input type="checkbox"/> Inpatient	<input type="checkbox"/> Day Patient	<input type="checkbox"/> Outpatient/ Sessional	Patient willingness and capacity to comply with program?: Yes/No																		
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<b>Section 2: ADMISSION DETAILS</b> Rehabilitation Diagnosis, Comorbidities and Complications: <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> <table style="width: 100%; border-top: 1px dotted black;"> <tr> <td style="width: 15%;"><b>Program:</b></td> <td style="width: 15%;"><b>Orthopaedic:</b></td> <td style="width: 15%;"><input type="checkbox"/> Upper Limb</td> <td style="width: 15%;"><input type="checkbox"/> Lower Limb</td> <td style="width: 15%;"><input type="checkbox"/> Joint Replace</td> <td style="width: 15%;"><input type="checkbox"/> Spinal Surgery</td> <td style="width: 15%;"><input type="checkbox"/> Mixed</td> </tr> <tr> <td></td> <td><b>Neurological:</b></td> <td><input type="checkbox"/> Parkinsons</td> <td><input type="checkbox"/> Peripheral</td> <td><input type="checkbox"/> Diffuse CNS</td> <td><input type="checkbox"/> Spinal</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Traumatic Brain Injury</td> <td colspan="4"><input type="checkbox"/> Non Traumatic Brain Injury (Stroke)</td> </tr> <tr> <td></td> <td><b>Other:</b></td> <td><input type="checkbox"/> Amputee</td> <td><input type="checkbox"/> Pain</td> <td colspan="3"><input type="checkbox"/> Reconditioning</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Cardiac (Phase 2)</td> <td colspan="4"><input type="checkbox"/> Major multiple trauma</td> </tr> </table>				<b>Program:</b>	<b>Orthopaedic:</b>	<input type="checkbox"/> Upper Limb	<input type="checkbox"/> Lower Limb	<input type="checkbox"/> Joint Replace	<input type="checkbox"/> Spinal Surgery	<input type="checkbox"/> Mixed		<b>Neurological:</b>	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> Peripheral	<input type="checkbox"/> Diffuse CNS	<input type="checkbox"/> Spinal				<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Non Traumatic Brain Injury (Stroke)					<b>Other:</b>	<input type="checkbox"/> Amputee	<input type="checkbox"/> Pain	<input type="checkbox"/> Reconditioning					<input type="checkbox"/> Cardiac (Phase 2)	<input type="checkbox"/> Major multiple trauma			
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<b>Section 3: INPATIENT AND DAY PROGRAM REHABILITATION PLAN</b> <span style="float: right;">Date: _____</span>																																						
Expected Length of Stay: _____	Total Inpatient Days: _____	Total Same Days (Ambulatory): _____	over a total of _____ weeks																																			
The Plan will significantly improve the following:	<input type="checkbox"/> Cognitive Skills	<input type="checkbox"/> Strength/Fitness																																				
	<input type="checkbox"/> Communication/Swallowing	<input type="checkbox"/> Functional Independence - ADLS																																				
	<input type="checkbox"/> Gait Mobility/Balance	<input type="checkbox"/> Pain Management																																				
	<input type="checkbox"/> Joint Mobility/Flexibility																																					
<i>I the Treating Specialist certify that I have discussed the Rehabilitation Program with the Patient/Representative who agrees to actively participate in the Program.</i>																																						
Name: _____	Signature: _____	Date: _____																																				
Phone Number: _____		Fax Number: _____																																				
<b>Section 4: DISCHARGE STATUS</b>																																						
Actual Length of Stay (days): _____		Discharge Date: _____																																				
Discharge Destination: <input type="checkbox"/> Home		<input type="checkbox"/> Hostel	<input type="checkbox"/> Nursing Home <input type="checkbox"/> Other																																			