Australian Health Service Alliance

WOUND CARE CERTIFICATION

Hospital Name (Please Print)_____

Hospital Admission Date: Hospital Discharge date:

Hospital Admission Diagnosis:_____

Hospital Discharge Diagnosis:

Patient Name

Fund Name _____ and Membership Number: ❒❒❒❒❒❒❒❒

Number of acute hospital days replaced by Wound Care

Outpatient Wound Care Admission Diagnosis:_____

Date for first Service:

Number of proposed visits: (*Please refer to contract)*_____

Type of Wound Care:

Site of Wound:

Reason for Service:

Completion (of Outpatient Wound Care) date:

Care Co-ordinator/ NUM Name & Signature:

PLEASE FAX THIS DOCUMENT TO THE RELEVANT AHSA FUND PRIOR TO THE PATIENTS DISCHARGE FROM HOSPITAL And forward with the account on completion of outpatient wound care

Summary Utilisation and Outcome Data must be supplied to the Australian Health Service Alliance as part of contract renewal.
First Service should occur within 48 hours of discharge. Service Limits apply according to the Contract. Where service visits, in addition to contract limits are requested, prior authorisation must be sought from the relevant Fund. Certification must be ongoing.

Signature of Referring Doctor **Referring Doctor's Name (Please Print)** **Date**