Latrobe HEALTH SERVICES
EveryBody benefits from our health cover

# *PSYCHIATRIC OVERNIGHT & PSYCHIATRIC DAY APPROVED PROGRAM CERTIFICATE*

| *For In-patient programs* | *Section 1 and 2 to be submitted with First and Interim claims.<br>Section 3 to be submitted with final claim.* | *For Day Programs:* | *Section 1 & 2 to be submitted with First Day and Interim claim<br>Section 3 to be submitted with Final claim* |
|---|---|---|---|

**Hospital Name:** ______________________________

**(Please Print)**

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

**Patient Name** ______________________________ **Membership No:** ☐☐☐☐☐☐☐☐

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 DSM IV 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
- ☐ Brief Psychotic Disorder Post Partum Onset
- ☐ Major Psychotic Disorder Post Partum Onset
- ☐ Post Traumatic Stress Disorder
- ☐ Eating Disorder-Anorexia Nervosa
- ☐ Eating Disorder-Bulimia Nervosa
- ☐ Other Diagnosis (Please Specify)

____________________
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____________________

Other Complicating Factors: (Please Specify) ______________________________

**Treatment Required**

- ☐ Psychotherapy Behavioural
- ☐ Psychotherapy Psychodynamic
- ☐ Psychotherapy Group
- ☐ Psychotherapy Other
- ☐ Living Skills
- ☐ Diversionals
- ☐ Detoxification
- ☐ E.C.T.
- ☐ Pharmacotherapy
- ☐ 1/1 Counselling
- ☐ Other (Please Specify)

## (Section 3) - Completion of Treatment/Discharge Status

**Next Treatment Phase**

- ☐ Home
- ☐ Nursing Home
- ☐ Community Care
- ☐ Refer to G.P.
- ☐ Day Program
- ☐ To 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** |
|---|---|---|

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