Rehabilitation Admission Certificate V5

Admission Type ☐ In Patient ☐ Out Patient ☐ Day Patient

Hospital Name: Patient Name:

Name of health fund: Date of Birth (or Age):

Membership No: Sex:

Rehab Program Name: UR Number:

Rehab Program Code: Admission Date:

Patient Normally Resides at: ☐ SRS/SAH ☐ Nursing Home ☐ Home ☐ Hostel

Admitted From: ☐ SRS/SAH ☐ Nursing Home ☐ Home ☐ Hostel

☐ Hospital Name: Dis Date: LOS:

Rehabilitation Admission Details

Admitting Diagnosis / Procedure	Description

Pre-Admission Assessment (InPatient only)

ACAT Assessment: No ☐ Yes ☐ Date: Approval for nursing home

Assessment for Nursing Home: No ☐ Yes ☐ Date: placement: No☐ Yes☐

Assessment by other rehabilitation Facility: No ☐ Yes ☐ Date: Hospital Name:

Was the Patient/Family informed of the expected rehabilitation outcomes: No ☐ Yes ☐ Why not:

Did the Patient/Family agree to the rehabilitation admission: No ☐ Yes ☐ Why not:

Patient needs nursing assistance with: ☐ Self Care ☐ Nutrition / Hydration

(may be more than one) ☐ Elimination ☐ Ambulation / Transfer

Patient has unstable co-morbidities: No ☐ Yes ☐ Details:

Assessed on:

By: Designation: Signature:

InPatient and Ambulatory Rehabilitation Plan

Drafted on:

Expected length of stay: Inpatient Days

and/or Total Outpatient program half hour sessions: over total no. of weeks:

or Total Same Days: over total no. of weeks:

The plan will significantly improve the following: (may be more than one)

☐ Cognitive Skills ☐ Strength / Fitness

☐ Communication / Swallowing ☐ Functional Independence - ADLs

☐ Gait Mobility / Balance ☐ Pain Management

☐ Joint Mobility / Flexibility

I (Treating Rehabilitation Consultant) certify that I have discussed the rehabilitation Program with the Patient/Representative

who agrees to actively participate in the program:

Name: Signature Date

Rehabilitation Discharge Certificate (Inpatients Only) V5

Hospital Name:
Name of health fund:
Membership No:
Rehab Program Name:
Rehab Program Code:

Patient Name:
Date of Birth (or Age):
Sex:
UR Number:
Admission Date:
Discharge Date:

Rehabilitation Episode	Diagnosis/Procedure Description	ICD-10	UDS
Rehabilitation Diagnosis/Procedure			
Secondary/Complication			
Secondary/Complication			

Preceding Diagnosis	Description	ICD-10
Acute Illness Diagnosis		
Secondary/Complication		
Principal Procedure		

FIM SCORES	Admission	Discharge
Self A:		
Self B:		
Self C:		
Self D:		
Self E:		
Self F:		
Sph G:		
Sph H:		
Xfr I:		
Xfr J:		
Xfr K:		
Loc L:		
Str M:		

FIM SCORES	Admission	Discharge
Com N:		
Exp O:		
Cog P:		
Cog Q:		
Cog R:		

FIM Easy Reference

7 Complete Independance
6 Modified Independance
5 Supervision
4 Minimal Assistance
3 Moderate assistance
2 Maximal Assistance
1 Total Assistance

Discharge Destination:

- ☐ SRS/SAH
- ☐ Nursing Home
- ☐ Home
- ☐ Hostel
- ☐ Other
- ☐ Hospital
- ☐ Death

Specify:
Hospital Name:

If Transferred was it:

- ☐ Planned
- ☐ Unplanned

Next Rehabilitation Phase:

- ☐ Nil
- ☐ Other Specify:

Private Rehabilitation Program

- ☐ Day Program
- ☐ Outpatient Program

Public Rehabilitation Program

- ☐ Community Rehabilitation Centre or Day Hospital
- ☐ Outpatient Program

Name: Signature Date