REHABILITATION PROGRAM CERTIFICATE Hospital: Certificate No: ☐ Inpatient ☐ Day Patient ☐ Outpatient/Sessional	Affix patient identification label here UR no Family Name: Given Names: Address DOB
Health Fund:	Fund Membership No:

Sections 1-3 to be submitted with first and interim claims, with first claim no later than 21 days

Section 4 to be submitted at time of discharge or alteration to program or setting.

Section 1: PREADMISSION ASSESSMENT

Pre-admission assessment performed?: yes/no if no, why?

Patient Source: ☐Community ☐Acute care Prog - this hospital ☐Acute care prog another hospital

If another Hospital ticked, please given name: ____

☐ Consulting Rooms ☐Hostel ☐Nursing Home

Patient assessed suitable for: ☐Inpatient ☐Day Patient ☐Outpatient/Sessional

Patient willingness and capacity to comply with program?: Yes/No

Section 2: ADMISSION DETAILS

Rehabilitation Diagnosis, Comorbidities and Complications:

Program: Orthopaedic: ☐Upper limb ☐Lower limb ☐Joint replace ☐Spinal Surgery ☐Mixed

Neurological: ☐Parkinson's ☐Peripheral ☐Diffuse CNS ☐Spinal

☐Traumatic Brain Injury ☐Non-traumatic Brain Injury (Stroke)

Other: ☐Amputee ☐Pain ☐Reconditioning

☐Cardiac Phase 2 ☐Major Multiple trauma

Section 3: INPATIENT AND DAY PROGRAM REHABILITATION PLAN

Date:

Expected Length of Stay:

Expected length of stay:	Total Inpatient Days:	Total Same days(Ambulatory): over a total of weeks

The plan will significantly improve the following:	☐Cognitive Skills	☐Strength Fitness
	☐Communication/Swallowing	☐Functional Independence - ADLS
	☐Gait Mobility/Balance	☐Pain Management
	☐Joint Mobility/Flexibility	

I the Treating Specialist certify that I have discussed the Rehabilitation Program with the Patient/Representative who agrees to actively participate in the Program.

Name: ______________________________ *Signature:* ____________________________ *Date:* ________________________

Phone Number: Fax Number:

Section 4: DISCHARGE STATUS

Actual length of Stay (days):	Discharge Date:
Discharge Destination: ☐Home ☐Hostel ☐Nursing Home ☐Other	