REHABILITATION PROGRAM CERTIFICATE HOSPITAL:	Affix patient identification label here UR no
Certificate No:	Family name:
□ Inpatient	Given names:
□ Day Patient	Address
□ Outpatient/Sessional	DOB: Sex □ M □ F

Health Fund:	Fund M'Ship 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: PRE-ADMISSION 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 give 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	□LowerLimb	□Joint Replace	□Spinal Surgery	□Mixed
	Neurological:	□Parkinsons	□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:	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