Acute Care Certificate

Section 1 – Particulars of Patient and Hospital (To be completed by Hospital, Doctor or Patient)

Patient's Surname _____ Christian or Given Names _____
Address _____ Postcode _____
Health Benefit Fund Membership Number _____
Name of Health Benefit Fund _____
Name of Hospital _____
Date of original admission ____/____/____ being the date from which the patient has been continuously An overnight patient in this or any other hospital(s), without a break of more than seven days.
Has patient been discharged Yes / No If Yes date of discharge ____/___/____
Has patient been transferred to another hospital please provide name_____
Has this patient had an ACAS (ACAT) assessment Yes / No
If Yes please detail date ___/___/___ and outcome _____

If ACAS (ACAT) assessment completed, attach a copy to this certificate.

Section 2 – Patient Authorisation (To be completed by Patient, Parent or Guardian or Power of Attorney)

I, _____ authorise Doctor _____ to release all information relevant to the condition(s) described in Section 3 below, including medical records and ACAS (ACAT) certificate if completed (Section 1).

Signature _____ Relationship _____ Date _____/_____/_____

Section 3 – Certification of Patient's Medical Condition (To be completed by Doctor)

I, _____ Telephone No. (_____)_____

of _____certify that I am providing professional attention to the above patient and certify they required/will require acute care for a maximum of 30 days from __/__/____ to __/__/____

Treatment Type (*tick the appropriate box*):

Psychiatric ☐ Acute Medical ☐ Acute Surgical ☐ Palliative Care ☐ Hospital in the Home ☐
Rehabilitation ☐ Nursing Home Transitional Care ☐ Other (specify) ☐ _____

Please state (1) The condition(s) requiring Acute Care:

1) _____
2) _____
3) _____

(2) The following co-morbidities/complications also required treatment during this admission:

	(Length of Chronicity)	(Diagnosis date)	(Treated during this treatment)
1) _____	( )	(/ /)	(yes/no)
2) _____	( )	(/ /)	(yes/no)
3) _____	( )	(/ /)	(yes/no)
4) _____	( )	(/ /)	(yes/no)
5) _____	( )	(/ /)	(yes/no)

Section 3 – Certification of Patient's Medical Condition (Cont) (Doctor to complete)

(3) Please list the interventions that are being provided that cannot be conducted in a nursing home:

Discipline	Services or Interventions	Frequency	End date
Surgeon/Physician			
Nursing			
Allied Health			

(4) Prognosis and opinion of probable duration of continuing need for Acute care):

_____

_____

_____

_____

_____

Signature _____ Date _____/_____/____