National Acute Care Certificate – Private Patient/Public Hospital

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

Patient's Surname________________________________Given Names____________________________________

Address____Postcode____________

Date of Birth ____/___/_____Gender M / F Name of Hospital ____

Health Fund Name ____Membership Number _______________________

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.

Certificate __________________ of this continuous admission (insert 1,2,3etc to show sequence)

Has the patient been discharged? [ ] Yes [ ] No If Yes, date of discharge /___/

Has the patient been transferred [ ] to, or [ ] from, another hospital?[ ] Yes [] No

If Yes, name of hospital ____

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

I, ______________________________________ authorise the ___________________________________ Hospital/and Health Service, to complete this certificate and release to my health fund or funding agency, all information relevant to the condition(s) that required acute care during the certified period including, but not limited to, medical records and other confidential and personal identifying and non-identifying information to confirm whether acute treatment has been provided and to verify the claims necessary to process the payment of accounts for treatment or diagnostic tests as described in Section 3 below.

Signature _________________________ Relationship _____________________________ Date _ ____/_____/_____

Section 3 – Certification of Patient's Medical Condition (to be completed byand/or certified by *treatingdoctor*)

I,____ Telephone No.___________________________

of____certify that the above patient:

[] no longer requires acute care; OR

[]required/will require acute care for at least the period commencing ______/___/___________

and ending _____/_____/______(no later than 30 days from commencement).

Treatment type during the certified period (tick the appropriate box):

[ ] Psychiatric [ ] Acute Medical [ ] Acute Surgical [ ] Palliative Care [ ] Hospital in the Home

[ ] Rehabilitation [ ] Other (specify) ____

Has the patient had an ACAS (ACAT) assessment during the certified period [ ] Yes [ ] No

Please state the condition(s) that required acute care during the certified period:

____

____

____

Please state the co-morbidities/complications that were also treated during the certified period:

____

____

____

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Section 3 – Certification of Patient's Medical Condition (cont)

Please document the services or interventions that describe the acute care provided to the patient in the certified period.

Discipline	Services or interventions (related to acute care)	Frequency (eg daily/3xweek etc)	Date ended
Surgeon/ Physician			
Nursing			
Allied Health			
Other			

If the patient has not been discharged, please state the prognosis and opinion of probable duration of the continuing need for acute care (to be completed by the treating doctor):

____

____

____

____

I confirm the information documented in Section 3 of this acute care certificate is accurate.

Signature of ***treatingdoctor***____

Name ***of treating doctor***____(please print)

Date: _______/___/____