AHSA Rehabilitation Discharge Certificate Hospital Name: Patient Name: Fund Name: Date of Birth or Age: ___ Male Female Fund Membership No: Sex: Rehab Program Name: UR Number: __/___/ Discharge Date: ____/___/_ Rehab Program Code: Admission Date: Diagnosis/Procedure Description ICD-10 Rehabilitation Episode Rehabilitation Diagnosis/Procedure Secondary/Complication Secondary/Complication ICD-10 **Preceding Diagnosis** Description Acute Illness Diagnosis Secondary/Complication Principal Procedure **AN-SNAP Details** Description Code **AROC Impairment Code** AN-SNAP Class FIM SCORES Admission Discharge **FIM SCORES** Admission Discharge 14. Comprehension Eating 15. Expression Grooming Bathing 16. Social Interaction Dressing - Upper Body 17. Problem Solving Dressing - Lower Body 18. Memory Toileting TOTAL COGNITIVE FIM 6. Bladder Management 8. Bowel Management FIM Easy Reference 7 Complete Independence Transfers - Bed / Chair / Wheelchair 9. 6 Modified Independence 10. Transfers - Toilet 5 Supervision Transfers - Bath or Shower 4 Minimal Assistance Locomotion - Walk / Wheelchair 12 3 Moderate Assistance 13. Stairs 2 Maximal Assistance TOTAL MOTOR FIM 1 Total Assistance Discharge Destination: □SRS/CCS (SRS - Supported Residential Services, CCS - Community Care Services) ■Nursing Home □Hostel □Home □ Death Other Hospital Name: ______ If Transferred was it: ☐ Hospital □Planned □Unplanned Next Rehabilitation Phase: ☐ Nil □Other Specify: Private Rehabilitation Program ☐ Day Program □Non-Admitted Program Public Rehabilitation Program ☐Community Rehabilitation Centre or Day Hospital □Non-Admitted Program

AHSA Version 2 November 2013

Name:

_____ Signature: ______ Date: _____ /__ /_