AHSA Rehabilitation Admission Certificate

Admission Type: ☐ Admitted Overnight ☐ Admitted Same Day ☐ Non-Admitted

Hospital Name: _____ Patient Name: _____

Fund Name: _____ Date of Birth or Age: _____

Fund Membership No: _____ Sex: ☐ Male ☐ Female

Rehab Program Name: _____ UR Number: _____

Rehab Program Code: _____ Admission Date: _____/_____/_____

Patient Normally Resides at: ☐ SRS/CCS ☐ Nursing Home ☐ Home ☐ Hostel

Admitted From: ☐ SRS/CCS ☐ Nursing Home ☐ Home ☐ Hostel

Hospital Name _____ Discharge Date: _____/_____/____ LOS_____

(**SRS** - Supported Residential Services, **CCS** - Community Care Services)

Rehabilitation Admission Details

Admitting Diagnosis/Procedure	Description
AROC Impairment Code	**Description**

Pre-Admission Assessment (Admitted Overnight Patients Only)

1. ACAT Assessment: ☐ Yes ☐ No Date: _____/_____/____ Approved for Nursing Home placement: ☐ Yes ☐ No
2. Assessment for Nursing Home: ☐ Yes ☐ No Date: _____/_____/____
3. Assessment by other Rehabilitation Facility: ☐ Yes ☐ No Date: _____/_____/____ Hospital Name:
4. Was the Patient/Family informed of the expected rehabilitation outcomes: ☐ Yes ☐ No Why Not:_____
5. Did the Patient/Family agree to the Rehabilitation admission: ☐ Yes ☐ No Why Not:_____
6. Patient needs nursing assistance with: *(you may tick more than one box)* ☐ Self Care ☐ Nutrition/Hydration ☐ Elimination ☐ Ambulation/Transfer
7. Patient has unstable co-morbidities ☐ Yes ☐ No Details:_____
8. Assessed on: Date: _____/_____/____
9. By:_____ 10. Designation: _____ 11. Signature:_____

Admitted Overnight and Ambulatory Rehabilitation Plan

Drafted on: ____/____/____

Expected Length of Stay: Overnight Days: _____

and/or Ambulatory program: _____ sessions over total no. of weeks: _____

The Plan will significantly improve the following: *(you may tick more than one box)*

☐ Cognitive Skills ☐ Strength/Fitness

☐ Communication/Swallowing ☐ Functional Independence/ADLs

☐ Gait Mobility/Balance ☐ Pain Management

☐ Joint Mobility/Flexibility

I (Treating Rehabilitation Consultant) certify that I have discussed the Rehabilitation Program with the Patient/Representative who agrees to actively participate in the Program:

Name: _____ Signature: _____ Date: _____/___/_____

Note: Ambulatory Rehabilitation includes full day, half day and sessional therapy programs