HOSPITAL IDENTIFICATION AND DIAGNOSIS FORM PHI (1)

DO NOT WRITE IN THIS BINDING MARGIN

FACILITY

U.R. NUMBER

ADMISSION NUMBER

ADMISSION DATE

ADMISSION TIME (0000 - 2359)

SEPARATION DATE

SEPARATION TIME (0000 - 2359)

CARE TYPE

01. Acute care
05. Newborn care
06. Other admitted patient care
07. Organ procurement
08. Hospital Boarder
09. Geriatric Evaluation & Management
10. Psychogeriatric care
11. Maintenance care
12. Mental Health care
20. Rehabilitation care
30. Palliative care (Record pallitive care details on PHI(2) form)

SOURCE OF REFERRAL/TRANSFER

01. Private med practitioner (excl. psychiatrist)
02. Emergency dept – this hospital
03. Outpatient dept – this hospital
06. Episode change
09. Born in hospital
14. Other health care establishment
15. Private psychiatrist
16. Correctional facility
17. Law enforcement agency
18. Community service
19. Routine readmission not requiring referral
20. Organ procurement
21. Boarder
23. Residential aged care service
24. Admitted patient transferred from another hospital
25. Non-admitted patient referred from other hospital
29. Other
30. Planned emergency
31. Residential mental health care facility
32. Change of reference period

If **16, 23, 24, 25** or **31** provide facility number

MODE OF SEPARATION

01. Home/usual residence
04. Other health care establishment
05. Died in hospital
06. Episode change
07. Discharged at own risk
09. Non return from leave
12. Correctional facility
13. Organ procurement
14. Boarder
15. Residential aged care service
16. Hospital transfer
17. Medi-hotel
19. Other
31. Residential mental health care facility
32. Change of reference period

If **12, 15, 16,** or **31** provide facility number

PLANNED SAME DAY (Y OR N)

ELECTIVE PATIENT STATUS
1. Emergency 2. Elective 3.Not Assigned

TREATING DOCTOR ON ADMISSION

TREATING DOCTOR ON SEPARATION

SMOKING STATUS 1.Current Smoker 2. Non-Smoker 9. Unknown

SMOKING PATHWAY COMPLETED N = No P = Partial Y = Yes

QAS IDENTIFICATION NUMBER

INCIDENT DATE

ESTIMATED INCIDENT DATE FLAG
1 = Estimated

MOTHER'S PATIENT ID
(where source of referral is 09 - Born in Hospital)

WARD DETAILS (Record additional ward/unit transfers on PHI(2) form)

ADMISSION WARD

ADMISSION UNIT

STANDARD UNIT CODE

STANDARD WARD CODE

ACCOUNT VARIATION DETAILS (Record account variation changes on PHI(2) form)

CHARGEABLE STATUS
1. Public 2. Private Shared 3. Private Single

COMPENSABLE STATUS
1. Workers' Compensation (Qld)
2. Workers' Compensation (Other)
3. Compensable Third Party
4. Other compensable
5. Dept of Veterans' Affairs
6. Motor Vehicle (Qld)
7. Motor Vehicle (Other)
8. None of the above
9. Dept of Defence

PATIENT LEAVE DETAILS (Record additional leave details on PHI(2) form)

DATE OF STARTING LEAVE

TIME OF STARTING LEAVE

DATE RETURNED FROM LEAVE

TIME RETURNED FROM LEAVE

TREATING DOCTOR

SIGNATURE

DATE

Any extra morbidity codes, activity details or mental health details (Y or N), complete and attach PHI (2).

Any SNAP details (Y or N), complete and attach PHI (3).

ICU - *Length of Stay*
Time (hhhhhmm)

CONTINUOUS VENTILATION
Time (hhhhhmm)

CONGENITAL ANOMALIES
Fetus Number ICD Code

FAMILY NAME

GIVEN NAMES

AFFIX PATIENT LABEL

ADDRESS OF USUAL RESIDENCE

No. and Street

Suburb/town

Postcode State

Date of Birth Estimated DOB 1. Yes

MARITAL STATUS

1. Never Married
2. Married (registered and de facto)
3. Widowed
4. Divorced
5. Separated
9. Not stated/unknown

Country of Birth

INDIGENOUS STATUS

1. Aboriginal but not Torres Strait Islander Origin
2. Torres Strait Islander Origin but not Aboriginal Origin
3. Both Aboriginal and Torres Strait Islander Origin
4. Neither Aboriginal nor Torres Strait Islander Origin
9. Not stated/unknown

AUSTRALIAN SOUTH SEA ISLANDER 1. Yes 2. No 9. Not stated/unknown

SEX 1. Male 2. Female 3. Other

BABY ADMISSION WEIGHT
(where <2500g or <29 days)

FUNDING SOURCE

01. Health Service Budget (not covered elsewhere)
02. Private health insurance
03. Self-funded
04. Worker's compensation
05. Motor vehicle third party personal claim
06. Other compensation
07. Department of Veterans' Affairs
08. Department of Defence
09. Correctional facility
10. Other hospital or public authority (contracted care)
11. Health Service Budget (due to eligibility for Reciprocal Health Care Agreement)
12. Other
13. Health Service Budget (no charge raised due to hospital decision)
99. Not Known

HOSPITAL INSURANCE

7. Hospital Insurance 8. No hospital insurance 9. Not stated/unknown

BAND CONTRACT ROLE *A = Hosp A, B = Hosp B* CONTRACT TYPE *1=B, 2=ABA, 3=AB, 4=(A)B, 5=BA*

- Code purchaser if contract type = 1, contract role = B and public chargeable status
- Code the Other Hospital Identifier if contract type = 2, 3, 4 or 5 and contract role A or B

PURCHASER/PROVIDER IDENTIFIER

MEDICARE ELIGIBILITY

1. Eligible 2. Not Eligible 3. Not stated/unknown

MEDICARE NUMBER

DVA PATIENT DETAILS *(Where compensable status = 5)*

DVA FILE NUMBER

CARD TYPE G = Gold W = White

QUALIFICATION STATUS
A = Acute U = Unqualified

(Record qualification status changes on PH1(2) form)

CONTRACT LEAVE DETAILS
Complete table when patient transferred for contract service at another hospital

DATE TRANSFERRED FOR CONTRACT

DATE RETURNED FROM CONTRACT

FACILITY NUMBER CONTRACTED TO

MORBIDITY CODES
(e.g. ICD-10-AM)
PD - Principal Diagnosis
EX - External Cause
PR - Procedure
OD - Other Diagnosis
M - Morphology

CONTRACT FLAG (CF) (if applicable)
1. Contracted admitted procedure
2. Contracted non-admitted procedure

CONDITION ONSET FLAG (COF)
1. Condition with onset during the episode of care
2. Condition not noted as arising during the episode of care
9. Unknown or uncertain

	Prefix	ICD Code	Prodedure Date	CF	COF
1.	P D				
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Record additional morbidity codes on the PH(2) form.

JULY 2019

PATIENT ACTIVITY PAGE

FACILITY

U.R. NUMBER

ADMISSION NUMBER

ADMISSION DATE

ADMISSION TIME (0000 - 2359)

SURNAME

GIVEN NAME(S)

SEX 1. Male 2. Female 3. Other

DATE OF BIRTH

EXTRA MORBIDITY CODES
OD. Other Diagnosis, EX. External Cause, M. Morphology, PR. Procedure

CONTRACT FLAG (CF) (if applicable)
1. Contracted admitted procedure
2. Contracted non-admitted procedure

CONDITION ONSET FLAG
1. Condition with onset during the episode care
2. Condition not noted as arising during the episode of care
9. Unknown or uncertain

	Prefix	ICD Code	Prodedure Date	CF	COF
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					

	Prefix	ICD Code	Prodedure Date	CF	COF
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					

WARD DETAILS - Complete the fields below for any additional admission or standard ward/unit transfers

ADMISSION WARD	ADMISSION UNIT CODE	STANDARD UNIT CODE	STANDARD WARD	DATE OF TRANSFER (0000-2359)	TIME OF TRANSFER

PATIENT LEAVE DETAILS - Complete table every time patient goes on same day and overnight leave

DATE OF STARTING LEAVE	TIME OF STARTING LEAVE	DATE RETURNED FROM LEAVE	TIME RETURNED FROM LEAVE

CONTRACT LEAVE DETAILS - Complete table when patient transferred for contract service at another hospital.

DATE TRANSFERRED FOR CONTRACT	DATE RETURNED FROM CONTRACT	FACILITY NUMBER CONTRACTED TO

ACCOUNT VARIATION CHANGE DETAILS

CHARGEABLE STATUS CHANGE	DATE OF CHANGE	COMPENSABLE STATUS CHANGE	DATE OF CHANGE

QUALIFICATION STATUS CHANGE DETAILS

QUALIFICATION STATUS	DATE OF CHANGE

MENTAL HEALTH DETAILS - Required for all admitted episodes where the standard unit code is in the range PYAA to PYZZ (Mental Health Unit).

TYPE OF USUAL ACCOMMODATION

EMPLOYMENT STATUS

PENSION STATUS

FIRST ADMISSION FOR PSYCHIATRIC TREATMENT

REFERRAL TO FURTHER CARE

MENTAL HEALTH LEGAL STATUS INDICATOR

PREVIOUS SPECIALISED NON-ADMITTED TREATMENT

NURSING HOME TYPE PATIENT DETAILS.

START DATE	END DATE

PALLIATIVE CARE DETAILS Where care type is 30
FIRST ADMISSION FOR PALLIATIVE CARE TREATMENT
1. No previous admission for palliative care treatment
2. Previous admission for palliative care treatment

PREVIOUS SPECIALISED NON-ADMITTED PALLIATIVE CARE TREATMENT
1. No previous non-admitted service for palliative care treatment
2. Previous non-admitted service for palliative care treatment

NOTE: THIS FORM MUST BE COMPLETED FOR EVERY OCCASION OF PATIENT ACTIVITY OR WHERE EXTRA MORBIDITY CODES ARE TO BE REPORTED, AND MUST BE RETURNED TO THE STATISTICAL COLLECTIONS AND INTEGRATION UNIT WITH THE CORRESPONDING IDENTIFICATION AND DIAGNOSIS SHEET. ATTACH MULTIPLE ACTIVITY FORMS AS REQUIRED.

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HOSPITAL IDENTIFCATION AND DIAGNOSIS FORM - ACTIVITY PAGE PHI (2) JULY 2019