null
**PATIENT ACTIVITY FORM**

**U.R. NUMBER**

**ADMISSION DATE**

**ADMISSION TIME**

(0000-2359)

**SURNAME**

**GIVEN NAME(S)**

**SEX M=1 F=2 I=3**

**FACILITY**

**ADMISSION NUMBER**

**DATE OF BIRTH**

**CONDITION PRESENT ON ADMISSION INDICATOR (CP)**

1. Condition present on admission to episode of care
2. Condition arises during admission
3. Unknown or uncertain

**MOST RESOURCE INTENSIVE CONDITION FLAG (RI)**

1. Most Resource Intensive Condition

**EXTRA MORBIDITY CODES**

OD - Other Diagnosis, EX - External Cause, M - Morphology, PI - Procedure

**CONTRACT FL AG (CF) (If applicable)**

1. Contracted admitted procedure

**OTHER CO-MORBIDITY OF INTEREST FLAG (CI)**

1. Other Co-Morbidity of Interest

<table>
<thead>
<tr>
<th>Prefix</th>
<th>ICD code</th>
<th>Procedure Date</th>
<th>CF</th>
<th>CP</th>
<th>RI</th>
<th>CI</th>
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**ACTIVITY DETAILS**

**WARD/UNIT TRANSFER TABLE** - Complete ward/unit/standard unit transferred to and date/time of transfer

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<tr>
<th>WARD</th>
<th>UNIT</th>
<th>STANDARD UNIT CODE</th>
<th>STANDARD WARD CODE</th>
<th>DATE OF TRANSFER</th>
<th>TIME OF TRANSFER</th>
<th>WARD</th>
<th>UNIT</th>
<th>STANDARD UNIT CODE</th>
<th>STANDARD WARD CODE</th>
<th>DATE OF TRANSFER</th>
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**OUT ON LEAVE TABLE** - Complete table every time patient goes on overnight leave.

**DATE OF STARTING LEAVE**

**DATE RETURNED FROM LEAVE**

**TRANSFER FOR CONTRACT SERVICE TABLE** - Complete table when patient transferred for contract service at another hospital.

**DATE TRANSFERRED FOR CONTRACT**

**DATE RETURNED FROM CONTRACT**

**FACILITY NUMBER CONTRACTED TO**

**NURSING HOME TYPE PATIENT**

**START DATE**

**END DATE**

**ACTIVITY TABLE CHANGES**

**CHARGEABLE STATUS CHANGE**

**DATE OF CHANGE**

**COMPENSABLE STATUS CHANGE**

**DATE OF CHANGE**

**QUALIFICATION STATUS CHANGE**

**DATE OF CHANGE**

**SNAP DETAILS**

**SNAP EPISODE NO.**

**START DATE**

**END DATE**

**SNAP TYPE**

**ADL TYPE**

**ADL SUBTYPE**

**SCORE**

**PHASE TYPE**

**ADL DATE**

**MULTIDISCIPLINARY CARE PLAN FLAG**

**MULTIDISCIPLINARY CARE PLAN DATE**

**PROPOSED PRINCIPAL REFERRAL SERVICE**

**PRIMARY IMPAIRMENT TYPE**

NOTE: THIS FORM MUST BE COMPLETED FOR EVERY OCCASION OF PATIENT ACTIVITY OR WHERE EXTRA MORBIDITY CODES ARE TO BE REPORTED.