Note: The quality of the information produced about the services your facility provides depends on the data received from you. Please complete this form carefully and completely.

IDENTIFICATION AND DIAGNOSIS SHEET

Facility:

UR No.

Admission No.

QAS Patient ID No.

Family name

Given names

Sex (M=1 F=2 I=3)

Date of birth

Estimated date of birth 1. Yes

Address of usual residence

No and street

Suburb/Town

Postcode State

Home phone number

Personal mobile phone number

Business or work phone number

Medicare eligibility
1. Eligible 2. Not Eligible 9. Not stated/unknown

Medicare number

Pension number

Religion

Emergency contact

Next of kin

Address

Phone

Marital status
1. Never married 2. Married 2. Defacto
3. Widowed 4. Divorced 5. Separated
9. Not stated/unknown

Country of birth

Preferred Language

Interpreter Required

Australian South Sea Islander
1. Yes 2. No 9. Not stated/unknown

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

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

DVA Patient details Where compensable status = 5

DVA file number:

Card type: G=Gold W=White

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

Health fund code

Chargeable status
1. Public 2. Private Shared 3. Private Single

Care type
01. Acute
05. Newborn
06. Other care
07. Organ procurement
08. Boader
09. Geriatric Evaluation and Management
10. Psychogeriatic
11. Maintenance
20. Rehabilitation
30. Palliative

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

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 re-admission not requiring referral
20. Organ procurement
21. Boarder
23. Residential aged care service
24. Admitted patient transferred from another hospital
25. Non-admitted patient transferred from another hospital
29. Other

If 16, 23, 24 or 25, facility number:

If 09, mother's URN:

Admission Date **Adm Time** (0000-2359)

Adm Ward **Adm Unit** **QUAL Status** A. Acute U. Unq

Standard Unit Code **Standard Ward Code**

ICU - Length of Stay -Time (h h h h h m m)

Continuous Ventilation -Time (h h h h h m m)

Elective Patient Status:
1. Emergency 2. Elective 3. Not assigned

Baby admission weight (Where <2500g or <29days) gms

Contract Role A. Hosp. A, B. Hosp. B

Planned Same Day: Y. Yes N. No

Contract Type
1. B 2. ABA 3. AB 4. (A)B 5. BA

Purchaser / Provider Identifier
- 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.

Has the patient been discharged from any hospital in the last seven days? Y. Yes N. No

If yes, from which hospital?

Total Length of stay without breaks of more than seven days in previous hospitals?

Consent flags (Y=Yes N=No U=Unable to obtain)
Contact for feedback / DVA / Q-Comp / Dept. of Defence / MAIC

Separation date **Sep. time** (0000-2359)

Band **Separation no**

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

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

If 12, 15 or 16, facility number:

Criteria Led Discharge

Principal diagnosis

Other diagnoses (complications and comorbidities)

Proceedures

External cause of injury/poisoning

Place of occurrence

Incident date

Incident date flag 1. Estimated

Activity

LMO:

Address:

Discharge Letter / Summary dictated / Notification - Cancer / Infectious disease

Morbidity codes (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 present on admission indicator (CP) 1. Condition present on admission to episode of care 2. Condition arises during admission 9. Unknown or uncertain

Most Resource Intensive Condition Flag (RI) 1. Most Resource Intensive Condition

Other Co-Morbidity of Interest Flag (CI) 1. Other Co-Morbidity of Interest

	Prefix	ICD Code	Procedure Date	CF	CP	RI	CI
1	P D						
2							
3							
4							
5							

Record additional codes on the Activity Form

Treating doctor:

Signature:

Date:

Any activity details, SNAP details or extra morbidity codes? Y. Yes N. No

Attach Activity Form(s) as required.

DO NOT WRITE IN THIS BINDING MARGIN

JULY 2014

MR056 (B) PART 1

PATIENT ACTIVITY FORM

FACILITY

U.R. NUMBER

ADMISSION DATE

ADMISSION NUMBER

ADMISSION TIME (0000-2359)

SURNAME

GIVEN NAME(S)

SEX M=1 F=2 I=3

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

OTHER CO-MORBIDITY OF INTEREST FLAG (CI)
1. Other Co-Morbidity of Interest

CONDITION PRESENT ON ADMISSION INDICATOR (CP)
1. Condition present on admission to episode of care
2. Condition arises during admission
9. Unknown or uncertain

MOST RESOURCE INTENSIVE CONDITION FLAG (RI)
1. Most Resource Intensive Condition

	Prefix	ICD code	Procedure Date	CF	CP	RI	CI		Prefix	ICD code	Procedure Date	CF	CP	RI	CI
8								17							
9								18							
10								19							
11								20							
12								21							
13								22							
14								23							
15								24							
16								25							

ACTIVITY DETAILS

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

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

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 N^{O}.

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.

MR056 (B) (PART 2)

DO NOT WRITE IN THIS BINDING MARGIN

PUBLIC HOSPITAL PATIENT ACTIVITY FORM

JULY 2014