Appendix F

# Queensland Hospital Admission Guidelines

## Queensland Hospital Admitted Patient Data Collection (QHAPDC) 2026-2027 v1.0

DELIVERING FOR QUEENSLAND | Queensland Government

## Appendix F

Published by the State of Queensland (Queensland Heath), October 2026



This document is licensed under a Creative Commons Attribution 4.0 International licence (CC BY 4.0). To view a copy of this licence, visit creativecommons.org/licenses/by/4.0/
You are free to copy, communicate and adapt the work, as long as you attribute the State of Queensland (Queensland Health).

**For more information contact:**
Data Services Branch, Queensland Health, GPO Box 48, Brisbane QLD 4001,
email qhipsmail@health.qld.gov.au.
An electronic version of this document is available at
https://www.health.qld.gov.au/dsb/collections/qhapdc

**Disclaimer**

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information.

# Table of Contents


**Scope of Document** 4

**1 Principles for Admission** 4

**2 Same Day Acute Care Admissions** 6

2.1 Recommended for Admission Procedures (RAP) list ..... 6
2.2 Not Recommended for Admission Procedures (N-RAP) list ..... 6
2.3 No procedure (monitoring only) ..... 7
2.4 Same Day Private Admissions ..... 7
2.5 Subacute same day episodes ..... 7
2.6 Mental Health Day Programs ..... 7

**3 Emergency Department Admissions** 9

**4 Admissions enabled via Virtual Care** 10

**5 Care Types** 11

5.1 Care Type Assignment ..... 11
5.2 Retrospective Care Type Changes ..... 12

**6 Cancellation of admissions** 13

**7 Frequently Asked Questions** 14

***Appendix 1 Additional notes on Subacute and Non-Acute Patient (SNAP) care admissions*** 16

***Appendix 2 Development of the Recommended for Admission Procedures (RAP) and Not Recommended for Admission Procedures (N-RAP) lists*** 19

***Appendix 3 Certificate for Admitted Patient Care*** 20

# Scope of Document

The Queensland Hospital Admission Guidelines (the Guidelines) are a guide for all Queensland public hospitals and applies to public patients including public patients in private facilities.

Whilst these Guidelines include additional information such as the conditions/procedures whereby a patient may be admitted, it should be noted that these are a guide only and are not intended to override a clinical decision to admit a patient by the treating health practitioner.

# 1 Principles for Admission

The following principles are to be read in conjunction with the information provided in the *Queensland Hospital Admitted Patient Data Collection Manual* related to admissions (QHAPDC).

The decision to admit a patient is primarily a clinical decision to be made by a clinician, with admitting rights to the facility, who must determine that the patient requires admission. There must be sufficient evidence documented in the patient record to justify the clinical determination that admission is required.

1.1. The decision to admit a patient is to be based on the following:

- Patient's condition and clinical needs.
- The facility's ability to meet those needs, including the availability of appropriate clinical resources.
- Other care and treatment options have been considered and determined not to be optimal for that patient at that time.
- Legal requirement to admit the patient.
- Other exceptional circumstances.

1.2. The decision to admit a patient should not be influenced by:

- the facility's key performance indicators
- the treatment location or
- the patient's financial status
- Funding arrangements

1.3. Admissions, regardless of location i.e. hospital ward, virtual ward) must be accompanied by a Patient Election Form (PEF)[1]. The PEF provides the patient with the opportunity to:

- Choose to be treated as a private or public patient.
- Consent to the release of patient details to certain funding agencies identified on the form (such as Department of Veteran Affairs, Motor Accident Insurance Commission etc) to ensure that, where appropriate, the patient's treatment is funded by these agencies. Current legislation does not permit Queensland Health to release a patient's details without the patient's specific consent to release the details for a specific purpose.
- The funding arrangements between the Australian Government and the Queensland Government make it very clear that every eligible patient should make an informed choice to receive public hospital services as a public or private patient.

1.3.1. Adherence to the Guidelines should not restrict local innovation in clinical practice or development of alternative models of care.

1.3.2. Hospital and Health Services (HHSs) will provide the strategic and operational direction through which these Guidelines are implemented, ensuring compliance with other Queensland Health directives and as well as individual HHS contractual arrangements with the department.

1.3.3. Evidence of clinical handover, by way of 'discharge summary', must be available in the patient's medical record' within an appropriate timeframe.

1.3.4. For Queensland Public Hospitals, the department has discretion to audit admissions to determine whether they meet the minimum evidence requirements for meaningful care required for healthcare funding arrangements.

[1] In some instances, the patient will be unable to complete a PEF (e.g. they are unconscious or in a critical condition on arrival). If the patient is unable to complete a PEF upon admission, please follow your facility's procedure for collecting this information when the patient cannot provide consent. The PEF must be filed in the patient's medical record.

# 2 Same Day Acute Care Admissions

The following section provides guidance on admissions under the **acute care** type with the intention of being same day, that is admitted to hospital and separated on the same day. This includes admissions to Emergency Department Short Stay Treatment Areas (EDSTTA), formally referred to as Emergency Department Short Stay Units (EDSTU) and Observation Wards[2].

For information on same day admissions for subacute care types and Mental Health Day Programs refer to Sections 2.5. and 2.6 in this document.

Patients requiring same day admitted **acute** care (as determined via a clinical decision) will fall into one of three categories, outlined below, depending on whether the patient is to be admitted for a procedure or being monitored only.

Please also refer to the Admission Decision Pathway (Figure 1) as a step by step guide to admission practices for same day and overnight patients across all care types.

## 2.1 Recommended for Admission Procedures (RAP) list

The patient, following a clinical decision, requires a procedure from the Recommended for Admission Procedures (RAP) list[3]. Procedures from the RAP list are considered to be sufficiently complex to require an in-patient admission. The RAP list is only accessible via the Queensland Health Intranet - https://qheps.health.qld.gov.au/dsb/datacollections#qhapdc [accessed 28 October 2026].

## 2.2 Not Recommended for Admission Procedures (N-RAP) list

The patient, following a clinical decision, requires a procedure from the Not Recommended for Admission Procedures (N-RAP) list. Procedures from the N-RAP list are considered safe to be provided in a non-admitted/outpatient setting. The N-RAP list is only accessible via the Queensland Health Intranet - https://qheps.health.qld.gov.au/dsb/datacollections#qhapdc [accessed 28 October 2026].

If procedures from the N-RAP list are the only procedures being performed, the admission will require the treating medical officer to document the reason for admission in the patient's medical record. Alternatively, a Certificate for Admitted Patient Care can be completed by the

[2] Please note for specific information on admissions to Emergency Department Short Stay Treatment Areas, please refer to the Emergency Department Short Term Treatment Areas (EDSTTA) Guidelines (QH-GDL-352:2022). Also refer to Section Three in this document, specifically on admission of patients after they have presented to the Emergency Department.

[3] Patients undergoing ECT/TMS may be eligible to be admitted under the Mental Health care type and therefore not subject to the RAP and N-RAP procedure lists.

treating doctor, or a suitably qualified nominee, and filed in the patient record. See Appendix Three of this document for further information on the use of this certificate.

## 2.3 No procedure (monitoring only)

The patient, following a clinical decision is expected to be admitted with the primary intent of receiving same day medical observation/care (without a procedure).

Admissions under this category are monitored by the department, as same day acute care admissions should primarily fall under the EDSTTAs. If this is not the case, the treating medical officer must document the reason for admission in the patient's medical record. Evidence in the medical record must meet the meaningful care standard.

Alternatively, a Certificate for Admitted Patient Care can be completed by the treating doctor, or a suitably qualified nominee, and filed in the patient record. See Appendix Three for further information on the certificate.

## 2.4 Same Day Private Admissions

The conditions and requirements (including certification) for same day admissions for private patients in public hospitals are specified in the *Private Health Insurance (Benefit Requirements) Rules 2011*. Certification for private patients is documented in the *Patient Hospital Claim Form*.

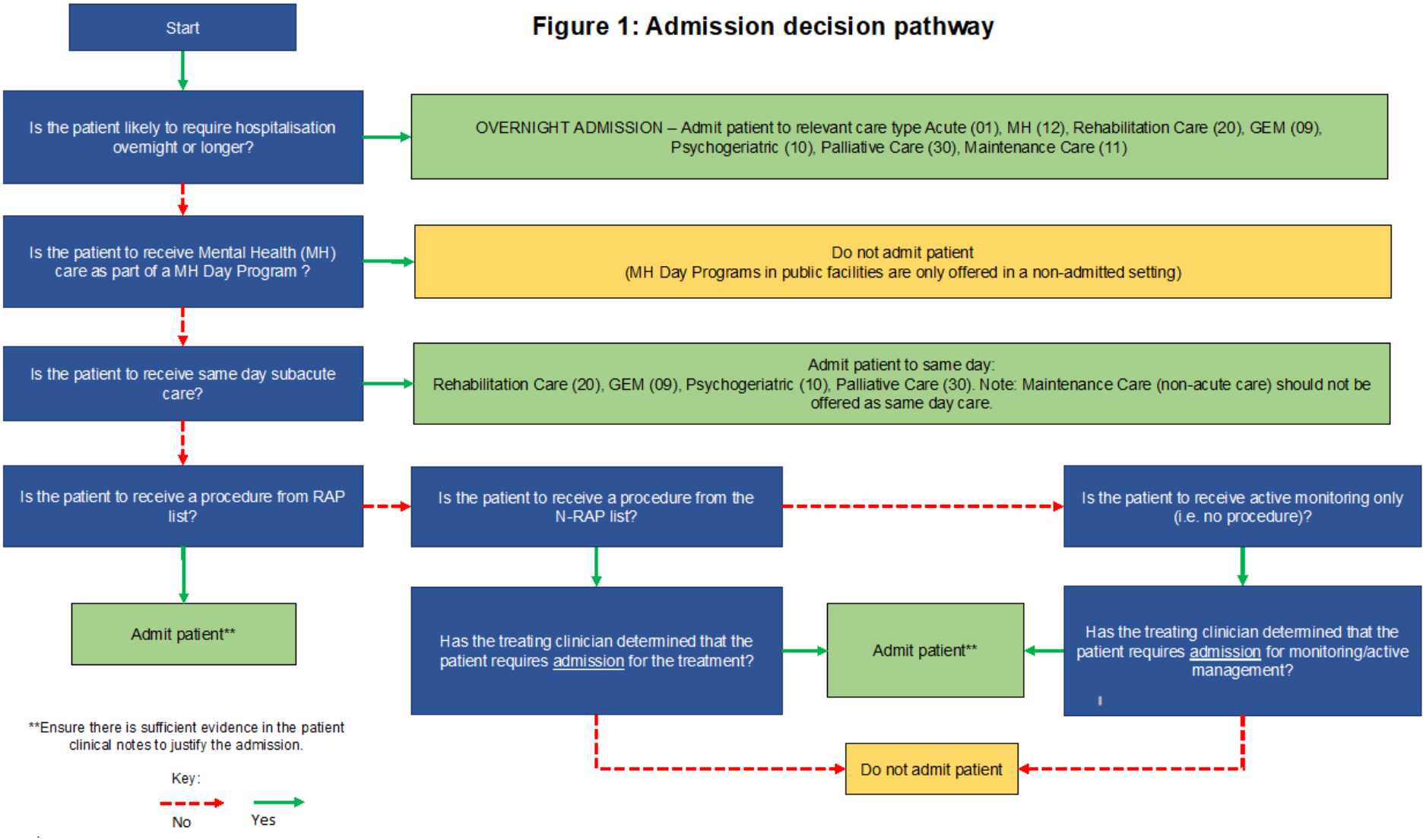
## 2.5 Subacute same day episodes

Patients admitted for same day Rehabilitation Care, Palliative Care, Geriatric Evaluation and Management and Psychogeriatric Care must be provided care according to the definitions for each care type as described in the *Queensland Health Data Dictionary*. There must be sufficient evidence documented in the patient record to justify the clinical determination that a same day subacute admission is required. Same day admissions for non-acute care (i.e. Maintenance care) are not considered appropriate. Appendix One contains further guidance on sub and non-acute care.

## 2.6 Mental Health Day Programs

Patients participating in a Mental Health Day Program in a public hospital are generally treated as non-admitted patients.

## Figure 1: Admission decision pathway



# 3 Emergency Department Admissions

Patients treated as Emergency Department (ED) presentations are not admitted patients. Admission, either to an inpatient space or an ED Short Term Treatment Area (EDSTTA), occurs subsequent to this assessment and management. Procedures such as sedation, resuscitative procedures, and minor emergency procedures are considered part of normal ED care (non-admitted care) and usually occur either in the resuscitation room, procedure room or other acute area of the ED. Patients that present to the ED, where a clinical decision is made to admit the patient, may be formally admitted to the hospital and relocated to an appropriate treatment environment such as an EDSTTA, inpatient ward, or operating theatre.

The Queensland Emergency Department Strategic Advisory Panel (QEDSAP) has developed the following position statement on the administrative management of patients in the ED.

- If and when a clinical decision is made to admit an emergency patient, the associated administrative process should occur in real time or near to real time;
    - Patients requiring an admission under management of the emergency care team should be admitted to the department's EDSTTA. These admissions should also adhere and align with the *Queensland Emergency Department Short Term Treatment Areas (Guideline)*;
    - Routine retrospective administrative changes to the admission status of hospital patients are not supported, unless the reason for this is to correct an error. Please also refer to Section One in this document on Principles for Admission;
    - ED patients requiring an outbound interhospital transfer from ED may be admitted to an appropriate inpatient or EDSTTA environment at the referring hospital when transfer is likely to be delayed and the patient is clinically suitable for care within the EDSTTA or inpatient environment; and

For public hospitals, deceased patients are not admitted into HBCIS as inpatients and are instead recorded as deceased using the deceased function in HBCIS via the registration screen.

In 2023, it was highlighted that many public hospitals have historical admission practices in their Emergency Department's outside of their EDSTTA as stipulated above and as such historical admission practices are still permitted up to a baseline, as described in 'Admissions to Emergency Department Ward' specification sheet. Admissions to Emergency Departments over and above this baseline will not be incorporated into the Hospital and Health Services' activity reconciliation as described in the NHRA Target 1 Activity Reconciliation specification sheet. Hospitals will be encouraged to reduce their admission practices over a period of time consistent with future standards to be developed by the Healthcare Purchasing and Funding Branch.

# 4 Admissions enabled via Virtual Care

Virtual Care is a method for healthcare delivery using technology where the participants are in different locations.

Virtual care in terms of admitted patient care, is an emerging model of care delivery where patients can be monitored or assessed remotely by a clinical team/s for the duration of their episode of care.

To determine that the care provided is admitted patient care the following principles should be applied in addition to those outlined in Section 1: Principles of Admission:

Patient meets the admission criteria.

The care standard must be equal to the care for a hospital admission.

The authorising practitioner supports that the patient admission can be managed via their Hospital In The Home (HITH) program (see section 4.9 Hospital in the home). Evidence that a treating clinician identifies the need for continuous monitoring and accepts responsibility for the patient during the episode of admitted patient care.

Evidence in the medical record that the patient has acknowledged and consents to being treated as an admitted patient for the duration as specified by the treating clinician.

There is evidence in the medical record of the patient receiving daily clinical care, over video or telephone and an active care plan is being followed, as would be provided to a patient on a ward.

Episodes of care within the same hospital facility should remain continuous where the type of care provided to the patient remains the same. E.g.: acute to acute care. This applies to admitted patients treated through virtual care that may also require clinical care physically within a hospital facility during their episode of care and vice versa. The change of location/ward is administratively to be recorded as a ward transfer.

The admissions are coded and there is sufficient documentation in the medical record to support the coding process.

Regular audits of virtual care documentation should be undertaken to ensure that medical record documentation and admission practices are operating within this guideline.

# 5 Care Types

Care type refers to the nature of the clinical care provided to a patient during an episode of (admitted) care. The care types collected under the QHAPDC are outlined in Table 1. Please refer to the *Queensland Health Data Dictionary* for definitions of each care type.

Only one type of care can be assigned at a time. In cases where a patient is undergoing multiple types of care, the care type that best describes the primary clinical purpose or treatment goal should be assigned. As such, whilst there may be other comorbidities present it is the primary issue that guides the assignment of care type.

**Table 1: Care Types**

| | Code | Care Type Description | |
|---|---|---|---|
| **Admitted Care** | 01 | Acute Care | |
| | 05 | Newborn Care | |
| | *09* | *Geriatric evaluation and management* | *Collectively known as Sub Acute & Non-acute Patient (SNAP) Care* |
| | *11* | *Maintenance Care* | |
| | *20* | *Rehabilitation care* | |
| | *30* | *Palliative care* | |
| | 12 | Mental Health care | |
| | 06 | Other admitted patient care[4] | |
| **Care other than Admitted care** | 07 | Organ procurement-posthumous | |
| | 08 | Boarder | |

**Please note that the care type '07 – Organ Procurement-posthumous' is not available in the Queensland Health patient administration system (HBCIS).*

## 5.1 Care Type Assignment

Care type is assigned as part of the patient admission process and recorded in the Patient Administration System (PAS) at the time of admission.

[4] Although 'Other Admitted Patient Care' exists within the reporting framework it should not be used except in exceptional circumstances.

Allocation of care type is ultimately the decision of the clinician who is managing and delivering the care to the patient. Sometimes there will be cases where it may be difficult to determine what the care type should be. The following steps may assist this process:

**Step 1**

Determine the PRIMARY clinical purpose or treatment goal of the patient's care. Whilst this may be impacted by comorbidities, it should not be governed by them.

**Step 2**

Read the care type definitions in the *Queensland Health Data Dictionary* and find the one that is most closely aligned with the primary clinical purpose and determine if there are any conditions that need to be met.

For example, rehabilitation care must:

- be delivered under the management of or informed by a clinician with specialised expertise in rehabilitation;
- include a formal assessment of function (Activity of Daily Living score); and
- be accompanied by a multi-disciplinary care plan that is documented in the patient record.

If these conditions cannot be met a rehabilitation care type should not be assigned.

**Step 3**

Ensure that any care type allocation is clearly documented in the patient's medical record. For further information and examples refer to Independent Hospital and Aged Care Pricing Authority (IHACPA) document *Admitted Hospital Care Types: Guide for use*.

## 5.2 Retrospective Care Type Changes

Care type should not be retrospectively changed in the PAS unless:

- it is for the correction of a data recording error, or
- the reason for the change is clearly documented in the patient's medical record and it has been approved by the hospital's Director of Clinical Services[5] or equivalent.
- At all times there must be documented evidence of the care a patient is receiving that supports the care type.

[5] From Admitted Hospital Care Types: Guide for use

# 6 Cancellation of admissions

Cancellation of an admission in the PAS and omission from the QHAPDC may sometimes be appropriate for consistency and validity of reporting. Policies and processes for the cancellation of admissions in the PAS are generally at the discretion of the facility/HHS however the following admissions should be reported despite the procedure subsequently being cancelled/unable to be performed:

- The procedure is minimally invasive in nature but has commenced e.g. for dialysis, infusion, transfusion.
- Anaesthesia has already been administered.
- The patient is already in the operating theatre or procedure room (endoscopy procedure room, cardiac catheterisation lab).
- The patient has received a pre-medication.

The reason for the procedure not being progressed must be clearly documented in the patient record.

# 7 Frequently Asked Questions

### *Q. Do all patients with private health insurance have to be admitted as private patients in public hospitals?*

On admission to a public hospital, patients are to be informed of their right to elect for private or public status and complete a Patient Election Form. They are not to be pressured to elect for private status simply because they hold private health insurance.

Where patients are unable to elect status or are unsure of status, in the case of compensable or Department of Veteran's Affairs patients, they should be assigned public status until such time as their status can be established.

### *Q. Should a person be admitted solely to receive treatment such as dialysis, chemotherapy or radiotherapy?*

Refer to the *RAP* and the *N-RAP* lists to guide acute same day admissions. Patients undergoing procedures on the *N-RAP* list should be treated on an outpatient basis unless there is a clinical decision/requirement to admit the patient (see Section 2.4). Private patients in public hospitals are subject to the *Private Health Insurance (Benefit Requirements) Rules 2011*.

### *Q. Where a person is required to attend the hospital for pre-operative preparation/work- up, should this be counted as the first day of admission, a day-only admission, or not at all?*

The recommended practice is to provide this as an outpatient occasion of service, **unless** there are exceptional circumstances requiring admission e.g. patients travelling long distances to attend the procedure. The reasons for an early admission must be documented in the patient record.

### *Q. What about patients admitted for routine management of their diabetes. The patient may receive several procedures on the N-RAP list (including allied health interventions) that could take several hours.*

If the care planned for the patient does not meet the criteria for admission to receive *Same Day Medical Observation/Care* however there is a clinical decision that the patient would be more appropriately treated if admitted, a Certificate for Admitted Patient Care is to be completed and filed in the patient record. Consideration may also be made regarding treating similar patients in an outpatient setting.

### *Q. What admission time should be reported for patients being admitted from the ED?*

The QHAPDC Manual states: *The admission time is the time at which a medical practitioner makes the decision that the patient should be admitted, noting that this may not be the time the patient arrived at the facility.*

*Example: If a patient arrives at the Emergency Department at 7 pm and at 11 pm the treating medical practitioner decides that the patient requires admission to the hospital, the admission time for the acute episode of care will be 11 pm.*

### *Q. What care type should be assigned to a patient requiring Electroconvulsive Therapy: Mental Health or Acute?*

Assignment of the Mental Health care type should be according to the definitions provided in the *Queensland Health Data Dictionary* and not the procedure/treatment intended for the patient. Therefore, care type assignment will be dependent on the PRIMARY clinical purpose or treatment goal of the patient's care.

### *Q. What about patients that attend an outpatient clinic for a scan or assessment and then a clinical decision is made to admit the patient to receive treatment? How should this be reported?*

If the assessment and treatment are administered in what would be considered a single, uninterrupted event (i.e. same location, same clinical team) **and** there is a clinical decision by the treating clinician to admit the patient, this should be reported as a single admitted episode of care.

If the assessment and treatment are clearly two separate events (i.e. broken by time, clinical team, patient location etc) **and** there is a clinical decision to admit the patient for treatment, then the services should be reported separately i.e. recorded as an outpatient clinic attendance and a subsequent inpatient admission.

# Appendix 1 Additional notes on Subacute and Non-Acute Patient (SNAP) care admissions

**Subacute care** comprises the following admitted Care Types:

- Rehabilitation Care
- Palliative Care
- Psychogeriatric Care
- Geriatric Evaluation and Management (GEM)

As specified in the definitions for each subacute care type[6], care is to be delivered under the management of or informed by a clinician with specialised expertise in that area.

A 'clinician' with specialised expertise can be a medical, nursing or allied health professional with recognised clinical skills in the specific area. These skills may be obtained via a specialist qualification, advanced training, relevant and peer recognised clinical experience[7]. Subacute care may be co-ordinated/provided by a multi-disciplinary team that may or may not be directly assigned to the ward but may work across a facility or facilities.

The admitting medical officer is ultimately responsible for the patient and needs to be sufficiently sure of the following:

- the patient requires subacute care, and the care is not simply to move the patient out of acute care.
- care provided will be delivered by clinician/clinicians with suitable expertise (as outlined above)
- care provided meets the definitions outlined in the *Queensland Health Data Dictionary* including:
    - existence of Multi-Disciplinary Care Plan documented in the patient record
    - negotiated goals within indicative time frames
    - formal assessment of functional ability

**Non-acute Care** comprises:

- Maintenance Care

A patient is classified as maintenance care when no active treatment is being provided for acute conditions. Maintenance Care (non-acute care) does not require care to be delivered by or informed by a clinician with specialist expertise. A multi-disciplinary care plan is not required; however, Maintenance Care patients should undergo a functional assessment. Maintenance care type is not acceptable as a virtual admission.

[6] Refer to Queensland Health Data Dictionary for SNAP care type definitions
[7] Adapted from: Sub-Acute Care Type Policy Guidance, NSW Agency for Clinical Innovation.

### Setting

Subacute and non-acute care does not necessarily need to be provided in designated units. As such the location of the patient is not pertinent to the assignment of a subacute or non-acute care type.

### Changing from Acute to Subacute or Non-Acute Care

A change of care type from acute to subacute or non-acute should only occur when the following conditions are met:

- The patient is deemed to be medically stable.
- The undergoing medical officer/physician is ready to take responsibility for the patient.
- Care according to the definitions is able to be delivered.

In some instances when the patient is medically stable but is temporarily unable to participate in a rehabilitation program, assignment to the maintenance care (non-acute) type until the patient can commence a rehabilitation program may be necessary.

The following example on care type changes is contained in the *IHPA Admitted Hospital Care Types - Guide for Use*

> *An 86-year-old female, who lives at home alone has had a fall and fractured her left and right humerus. After a week, the patient is deemed to be stable. The rehabilitation team review her and document that she will be accepted into a rehabilitation program once she has use (either partly or completely) of at least one of her arms. Her orthopaedic team anticipate that this may take up to three to four weeks.*
>
> *Decision: Once the patient has been deemed stable by her medical team, the patient should be transferred from an acute care type to a maintenance care type until she can participate in rehabilitation.*
>
> *Rationale: Once her medical team have determined that she is stable, the primary purpose of the treatment changes from management of her injuries to be supportive until she can participate in her rehabilitation program*[8]*.*

Note: patients can be directly admitted to subacute or non-acute care. There is no requirement for the patient to receive acute care prior to the SNAP admission.

### Subacute patients undergoing same day interventions

Patients, who receive acute same day interventions such as dialysis, during the course of a subacute or non-acute episode of care do not change care type. Instead, procedure codes for the acute same day intervention(s) and an additional diagnosis (if relevant) should be added to the record of the subacute episode of care.

[8] Independent Hospital Pricing Authority Admitted Hospital Care Types. Guide for Use. Commonwealth of Australia. 2015

To further clarify, if the intervention or procedure is ancillary to the admission and does not change the PRIMARY clinical purpose or treatment goal of the patient's care (that is the receipt of subacute care), then the care type should not change.

**Additional Information**

For further information on subacute and non-acute care data entry please refer to the *Sub and non-acute Patient Data Entry Guidelines.*

# Appendix 2 Development of the Recommended for Admission Procedures (RAP) and Not Recommended for Admission Procedures (N-RAP) lists

The lists were originally developed by the Victorian Department of Health and Human Services via the following process[9]:

1. Procedures listed in the *Private Health Insurance (Benefit Requirements) Rules 2011* as Type B, Surgical and Advanced Surgical, were 'mapped' from Medicare Benefit Scheme (MBS) codes to the relevant Australian Classification of Health Interventions (ACHI) codes to form the admitted patient code list.
2. ACHI codes that were not already captured and designated as 'operating room' procedure codes in either Version 5 or Version 6 Australian Refined Diagnosis Related Groups (AR-DRGs) were added to this list.
3. Any remaining ACHI code not included on the admitted list at the end of this process was placed on the non-admitted list.
4. Each ACHI code is allocated to one or the other of these lists and together covers all ACHI codes.
5. Further development of the lists involved feedback from health services (including coders and clinicians) and departmental representatives.

Further review and development of the lists was undertaken by the Queensland Health Statistical Services Branch Coding Consistency Special Interest Group and the Data Quality Improvement Working Group. Input was also obtained from the Clinical Coding Authority of Queensland.

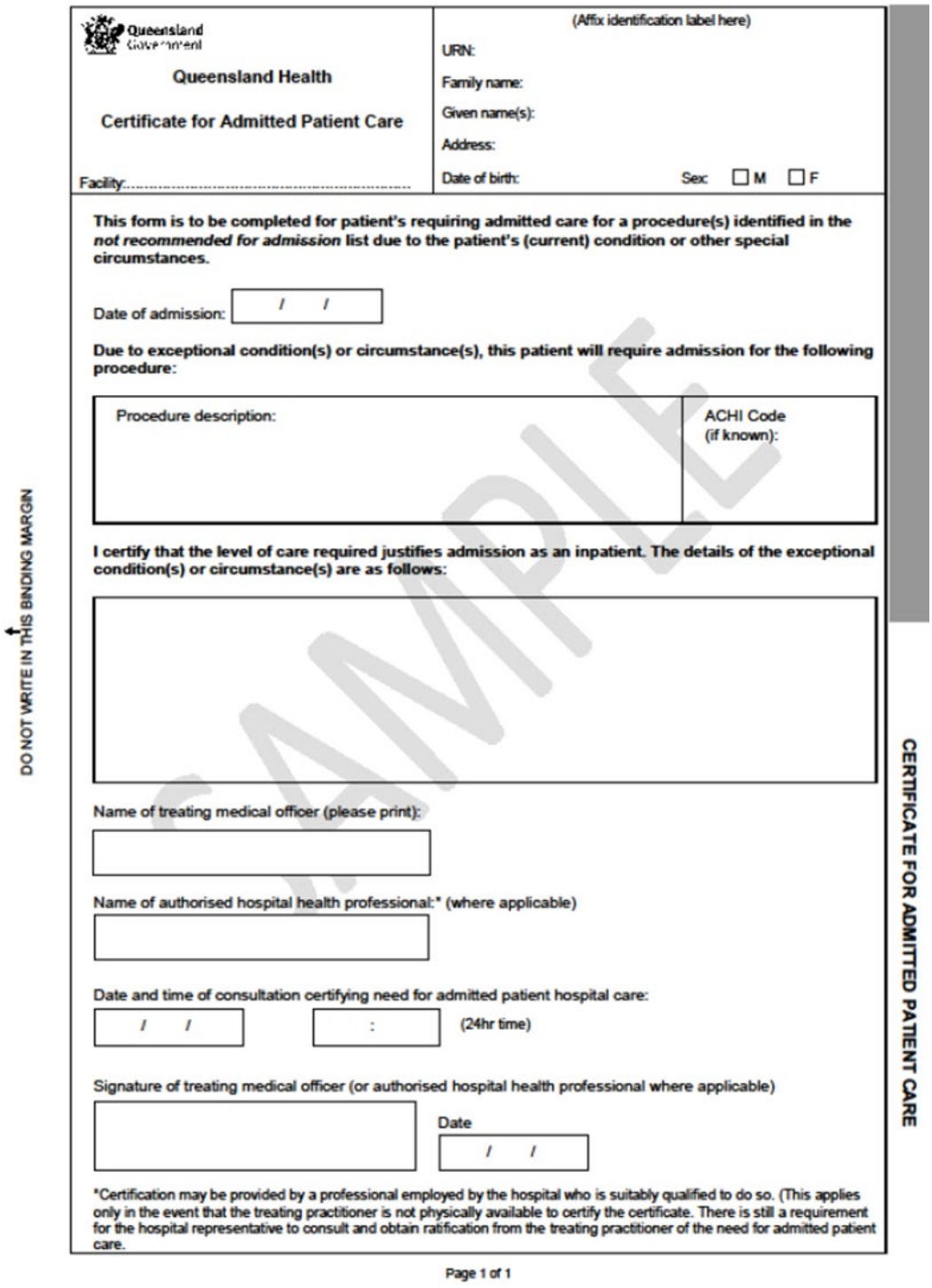
The lists will be reviewed annually in alignment with the review of the QHAPDC Manual. If HHSs consider that one or more procedures require in-year review the Healthcare Purchasing and Funding Branch will consider submissions. Please email submissions to HPFP-FCPM@health.qld.gov.au

[9] Source: Victorian Hospital Admission Policy Fact Sheet: 2015-16

# Appendix 3 Certificate for Admitted Patient Care

This form can be utilised to document the reason for admission and incorporated into the patient medical record. An example Certificate for Admitted Patient Care form is below. An editable PDF form is available on QHEPS.

Please note: If the treating practitioner is not available to provide certification, a professional employed by the hospital who is suitably qualified and been nominated to do so, may provide certification for the admission. There is still a requirement for the hospital representative to consult and obtain ratification from the treating practitioner of the need for admitted patient care.



Queensland Government

**Queensland Health**

**Certificate for Admitted Patient Care**

Facility:.....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

**This form is to be completed for patient's requiring admitted care for a procedure(s) identified in the *not recommended for admission* list due to the patient's (current) condition or other special circumstances.**

Date of admission: / /

**Due to exceptional condition(s) or circumstance(s), this patient will require admission for the following procedure:**

| Procedure description: | ACHI Code (if known): |
|---|---|
| | |

**I certify that the level of care required justifies admission as an inpatient. The details of the exceptional condition(s) or circumstance(s) are as follows:**

Name of treating medical officer (please print):

Name of authorised hospital health professional:* (where applicable)

Date and time of consultation certifying need for admitted patient hospital care:

/ / : (24hr time)

Signature of treating medical officer (or authorised hospital health professional where applicable)

Date / /

*Certification may be provided by a professional employed by the hospital who is suitably qualified to do so. (This applies only in the event that the treating practitioner is not physically available to certify the certificate. There is still a requirement for the hospital representative to consult and obtain ratification from the treating practitioner of the need for admitted patient care.

Page 1 of 1

DO NOT WRITE IN THIS BINDING MARGIN

CERTIFICATE FOR ADMITTED PATIENT CARE

SAMPLE