# Discharge Services Notification (DSN) for Adults - 16 Weeks

Once completed please e-mail this form to: care-requests@icare.nsw.gov.au and include the following in the subject header: DSN [Participant number] [Lifetime Care Contact Name]

* 1. **Participant’s details**

|  |  |  |
| --- | --- | --- |
| **Name** |  **Participant no.**  |  **Discharge destination** |
|   |   |   |
| **Diagnosis** |
| [ ]  **TBI****CANS:**   | [ ]  **SCI****Level:** ASIA Score:  | [ ]  **Other****Specify:**   |
| Does the participant have orthopaedic or other injuries requiring specific intervention | Does the participant require an interpreter? |
|  [ ]  Yes [ ]  No | [ ]  Yes [ ]  No If yes, which language:  |
| Would the participant like icare to consider (where possible) any cultural requirements when meeting their treatment, rehabilitation, and care needs? |
| [ ]  Yes [ ]  No If yes, provide details:  |

* 1. **Person completing this form**

|  |  |  |
| --- | --- | --- |
| Name  | Position | Phone |
|   |   |   |
| Organisation and ABN | Email |
|   |   |

* 1. **Discharge Services Period** (discharge services are maximum of 16 weeks)

|  |  |
| --- | --- |
| Start date | End date |
| Click or tap to enter a date. | Click or tap to enter a date. |

* 1. **Preapproved Services needed on discharge**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Type (includes report writing)** | **Code** | **Hours approved** | **Hours needed (total)** | **Hourly Rate** | **Provider Name****Organisation (billing as)****Address, ABN, Phone and Email** | **Travel hrs needed****(LTCS503)** | **Hourly Rate** | **Reason additional hours and/or provider travel are needed** |
| **Case Management** | LTCS501 | 40 |   |   |   |   |   |   |
| **Occupational Therapy**  | LTCS307 | 24 |   |   |   |   |   |   |
| **Neurological Physiotherapy** | LTCS303 | 16 |   |   |   |   |   |   |
| **Musculoskeletal physiotherapy** | LTCS303 | 8 |   |   |   |   |   |   |
| **Speech pathology** | LTCS305 | 16 |   |   |   |   |   |   |
| **Psychology (clinical or rehabilitation)** | LTCS302 | 16 |   |   |   |   |   |   |
| **Social work** | LTCS306 | 16 |   |   |   |   |   |   |
| **Work Options Plan** | LTCS201 | 6 |   |   |   |   |   |   |
| **Equipment follow-up / assessments** | Refer to certificate | 6 |   |   |   |   |   |   |
| **Care needs assessment** | Referral to be made by icare |  |   |   |   |   |   |   |
| **Continence or nursing assessment** | LTCS101 | 3 |   |   |   |   |   |   |
| **Recreation or leisure therapy, community integration** | LTCS405 | 8 |   |   |   |   |   |   |
| **Participant focused support worker training (therapist time)** | Refer to certificate  | 1 hour per therapist per worker |   |   |   |   |   |   |
| **Rehabilitation specialist reviews** | LTCS105 | 3 |   |   |   |   |   |   |
| **Other specialist reviews** | Refer to certificate | 1 review / specialist |   |   |   |   |   |   |
| **GP reviews** | LTCS908 | 4 reviews |   |   |   |   |   |   |
| **Pharmacy account\*** | LTCS911 | n/a | n/a |   |   |   |   |   |

\*to establish a pharmacy account icare requires a list of injury-related medications, ignore this row if the account has previously been established.

* 1. **Non pre-approved services needed on discharge**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Service Type**  | **Code** | **Hours needed (total)** | **Hourly Rate** | **Provider Name****Organisation (billing as)****Address, ABN, Phone and Email** | **Travel hrs needed****(LTCS503)** | **Hourly Rate** | **Reason additional hours and/or provider travel are needed** |
| **Neuropsychology Assessment** | LTCS119 |   |   |   |   |   |   |
| **Podiatry** | LTCS309 |   |   |   |   |   |   |
| **Dietetics** | LTCS304 |   |   |   |   |   |   |
| **Gym programs, hydrotherapy** | LTCS301 |   |   |   |   |   |   |
| **Driving assessment (must have medical clearance)** | LTCS404 |   |   |   |   |   |   |
| **Spinal Outreach Services, including Rural SCI Service** | LTCS101 |   |   |   |   |   |   |

\*if travel is required to attend appointments, please contact the icare contact to discuss options

* 1. **Additional information that may impact on Discharge (optional)**

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|   |

* 1. **Service provider declaration**

|  |  |
| --- | --- |
| Name  | Date |
|   | Click or tap to enter a date. |

|  |  |
| --- | --- |
|  | **Lifetime Care**GPO Box 4052, Sydney NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |