GMHBA HEALTH INSURANCE

Care Coordination Service Discharge Planning Form

Affix Bradmar Sticker

Section one Patient details

Name

Date of birth

Residential address

Suburb

State

Postcode

Member number

Phone number

Regular GP & Clinic name

Regular GP contact

NOK relationship & location

NOK name & contact

Section two Hospital admission summary

Admission date

Expected discharge date

Has the patient attended inpatient rehab?

◯ Yes ◯ No

Patient living situation

◯ Alone ◯ With spouse/ partner ◯ With family

◯ Other:

Reason for hospital admission

Co morbidities

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Allergies

Current services/packages/notes

Consultant Medical Officer

MAC referral ◯ Yes ◯ No

Reference number

Current functions

Mobility

- ◯ Nil aid
- ◯ Stick
- ◯ Crutches
- ◯ Frame
- ◯ Wheelchair

Skin integrity

- ◯ Intact
- ◯ Broken
- ◯ Specify

Cognition

- ◯ Alert/orientated
- ◯ Mildly confused
- ◯ Very confused

Personal care

- ◯ Independent
- ◯ Assistance
- ◯ Dependent

CCS services requested

- ◯ Physiotherapy
- ◯ Occupational therapy
- ◯ Personal care
- ◯ Equipment hire (specify)
- ◯ Domestic assistance
- ◯ Meals
- ◯ Nursing (specify)

Information attached (note: services cannot commence until received)

- ◯ Physiotherapy Summary
- ◯ Medication list
- ◯ Occupational therapy Summary
- ◯ Other (specify)

Practitioner

Total number of pages (including this form)

Section three Consent

I confirm the member has given consent for the information on the form to be shared with GMHBA

◯ Yes ◯ No

I confirm the member has given consent for NOK to speak with GMHBA on their behalf

◯ Yes ◯ No

How to use this form

Go ahead and complete all sections and then return all pages to ccs@gmhba.com.au via Secure File Transfer. If you have any questions about the CCS program, please contact us on 1300 426 668.