# 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]

## ****1.1 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** | | | |
| **Yes** | | **No** | |
| **Does the participant require an interpreter?** | | | |
| 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: | | | |

## ****1.2 Person completing this form****

|  |  |
| --- | --- |
| **Name** | **Position** |
|  |  |
| **Organisation** | **Phone** |
|  |  |
| **Email** | |
|  | |

## ****1.3 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. |

## ****1.4 Preapproved Services needed on discharge****

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service Type (includes report writing) | Code | Hours approved | Hours needed (total) | Hourly Rate | Provider Name  Organisation (billing as)  Address, 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.

## ****1.5 Non pre-approved services needed on discharge****

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Service Type | Code | Hours needed (total) | Hourly Rate | Provider Name  Organisation (billing as)  Address, 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

## ****1.6 Additional information that may impact on Discharge (optional)****

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## ****1.7 Service provider declaration****

The participant has been involved as much as possible in the development of this request in collaboration with their family member or nominated person if necessary. The participant (and family member or nominated person) agrees with this request.

|  |  |
| --- | --- |
| **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.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |