# 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 [Worker Claim Number] [Workers Care Contact Name]

## ****1.1 Worker’s Details****

|  |  |  |
| --- | --- | --- |
| **Name** | **Claim Number**  | **Discharge destination** |
|   |   |   |
| **Diagnosis** |
| [ ]  **TBI****CANS FIM score**  | [ ]  **SCI****Level**  ASIA Score  | [ ]  **Other****Specify**   |
| **Does the worker have orthopaedic or other injuries requiring specific intervention** |
| [ ]  **Yes** | [ ]  **No** |
| Does the worker require an interpreter? |
| [ ]  Yes [ ]  No If yes, which language?  |
| Would the worker 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 NameOrganisation (billing as)Address, Phone and Email | Travel hrs neededTravel codes | Hourly Rate | Reason additional hours and/or provider travel are needed |
| **Case Management** | OOT005 | 40 |   |   |   |  OTT006 |   |   |
| **Occupational Therapy**  | OAS002 | 24 |   |   |   |  OAS002 |   |   |
| **Neurological Physiotherapy** | PTA005 | 16 |   |   |   |  PTA014 |   |   |
| **Musculoskeletal physiotherapy** | PTA001 | 8 |   |   |   |  PTA014 |   |   |
| **Speech pathology** | OTT002 | 16 |   |   |   |  OTT006 |   |   |
| **Psychology (clinical or rehabilitation)** | PSY002 | 16 |   |   |   |  PSY005 |   |   |
| **Social work** | OTT006 | 16 |   |   |   |  OTT006 |   |   |
| **Return to work services\*** | OR02 | 6 |   |   |   |  OR04 |   |   |
| **Equipment follow-up / assessments** | Refer to Notice or OAD001 | 6 |   |   |   |   |   |   |
| **Care needs assessment** | Referral to be made by icare |  |   |   |   |   |   |   |
| **Continence or nursing assessment** | OAS001NUR101 if home | 3 |   |   |   |   |   |   |
| **Recreation or leisure therapy, community integration** | OAS002 | 8 |   |   |   |  OTT006 |   |   |
| **Worker focused support worker training (therapist time)** | PCA001 | 1 hour per therapist per worker |   |   |   |   |   |   |
| **Rehabilitation specialist reviews** | AE115 | 3 |   |   |   |   |   |   |
| **Other specialist reviews** | Refer to notice | 1 review / specialist |   |   |   |   |   |   |
| **GP reviews** | AA020 | 4 reviews |   |   |   |   |   |   |
| **Pharmacy account\*\*** | PSH001 | n/a | n/a |   |   | n/a |   | n/a |

\*Return to work services are required to be provided by a SIRA approved vocational provider and may include worksite assessment, liaison with employer and treating medical practitioner

\*\*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 NameOrganisation (billing as)Address, Phone and Email | Travel hrs neededTravel codes | Hourly Rate | Reason additional hours and/or provider travel are needed |
| **Neuropsychology Assessment** | IIN004 |   |   |   |   |   |   |
| **Podiatry** | OTT006 |   |   |   |  OTT006 |   |   |
| **Dietetics**  | OTT006 |   |   |   |  OTT006 |   |   |
| **Gym programs, hydrotherapy** | PTA006 |   |   |   |   |   |   |
| **Driving assessment (must have medical clearance)** | OAS002 |   |   |   |   |   |   |
| **Spinal Outreach Service, including Rural SCI Service** | PSI002 |   |   |   |  OTT006 |   |  |

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

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

|  |
| --- |
|   |

## ****1.7 Provider Declaration****

The worker 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 worker (and family member or nominated person) agrees with this request.

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

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