# Discharge Services Notification (DSN) for Children - 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 Child’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 or their guardian like icare to consider (where possible) any cultural requirements when meeting the participant’s 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 |  |  |  |  |  |  |
| **Physiotherapy** | LTCS303 | 24 |  |  |  |  |  |  |
| **Speech pathology** | LTCS305 | 16 |  |  |  |  |  |  |
| **Psychology** | LTCS302 | 16 |  |  |  |  |  |  |
| **Social work** | LTCS306 | 16 |  |  |  |  |  |  |
| **Work Options Plan** | LTCS201 | 6 |  |  |  |  |  |  |
| **Equipment follow-up / assessments** | Refer to certificate | 6 |  |  |  |  |  |  |
| **Care needs assessment (inc.**  **P-CANS 2 assessment)** | Referral to be made by icare |  |  |  |  |  |  |  |
| **Continence or nursing assessment** | LTCS101 | 3 |  |  |  |  |  |  |
| **Neuropsychology assessment** | LTCS119 | 10 |  |  |  |  |  |  |
| **School Visit / Assessment** | LTCS407 | 3 |  |  |  |  |  |  |
| **Educational Support (up to 8 hours per weeks during school term)** | LTCS407 | Up to 8 per week |  |  |  | n/a |  |  |
| **Participant focused support worker training (therapist time)** | Refer to certificate | 1 hour per therapist per worker |  |  |  |  |  |  |
| **GP reviews** | LTCS908 | 4 reviews |  |  |  |  |  |  |
| **Pharmacy account\*** | LTCS911 | n/a | n/a |  |  | 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 |
| **Podiatry/Orthotist** | LTCS309 |  |  |  |  |  |  |
| **Dietetics** | LTCS304 |  |  |  |  |  |  |
| **Gym programs, hydrotherapy** | LTCS301 |  |  |  |  |  |  |

\*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 Provider declaration****

### I have developed this request in consultation with the child’s parent/guardian.

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

This request has been discussed with the child’s parent/guardian and agreement has been obtained?

**Yes**  **No**

|  |
| --- |
| **If no, please briefly outline why the child’s parent/guardian does not agree with the plan** |
|  |

|  |  |
| --- | --- |
|  | icare 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 |