

DO NOT WRITE IN THIS BINDING MARGIN

FACILITY _____

U.R. NUMBER _____

ADMISSION NUMBER _____

ADMISSION DATE _____ ADMISSION TIME (0000 - 2359) _____

SEPARATION DATE _____ SEPARATION TIME (0000 - 2359) _____

CARE TYPE
 01. Acute care
 05. Newborn care
 06. Other admitted patient care
 07. Organ procurement-posthumous
 08. Hospital Boarder
 09. Geriatric Evaluation & Management
 10. Psychogeriatric care
 11. Maintenance care
 12. Mental Health care
 20. Rehabilitation care
 30. Palliative care (record palliative care details on PHI(2) form)

SOURCE OF REFERRAL/TRANSFER
 01. Private med practitioner (excl. psychiatrist)
 02. Emergency dept – this hospital
 03. Outpatient dept – this hospital
 06. Episode change
 09. Born in hospital
 14. Other health care establishment
 15. Private psychiatrist
 16. Correctional facility
 17. Law enforcement agency
 18. Community service
 19. Routine readmission not requiring referral
 20. Organ procurement
 21. Boarder
 23. Residential aged care service
 24. Admitted patient transferred from another hospital
 25. Non-admitted patient referred from other hospital
 29. Other
 30. Planned emergency
 31. Residential mental health care facility
 32. Change of reference period

MODE OF SEPARATION
 01. Home/usual residence
 04. Other health care establishment
 05. Died in hospital
 06. Episode change
 07. Discharged at own risk
 09. Non return from leave
 12. Correctional facility
 13. Organ procurement
 14. Boarder
 16. Hospital transfer
 17. Medi-hotel
 19. Other
 21. RACS not usual place of residence
 22. RACS usual place of residence
 31. Residential mental health care facility
 32. Change of reference period

PLANNED SAME DAY Y = Yes N = No _____ ELECTIVE PATIENT STATUS
 1. Emergency admission 2. Elective admission 3. Not Assigned

TREATING DOCTOR ON ADMISSION _____

TREATING DOCTOR ON SEPARATION _____

SMOKING STATUS
 1. Reported a current smoker within the last 30 days
 2. Reported not a current smoker
 9. No smoking status reported or documented

SMOKING PATHWAY COMPLETED N = No P = Partial Y = Yes _____

QAS IDENTIFICATION NUMBER _____

INCIDENT DATE _____ ESTIMATED INCIDENT DATE FLAG 1 = Estimated

MOTHER'S PATIENT ID (where source of referral is 09 - Born in hospital) _____

WARD DETAILS (Record additional ward/unit transfers on PHI(2) form)
 ADMISSION WARD _____ ADMISSION UNIT _____
 STANDARD UNIT CODE _____ STANDARD WARD CODE _____

ACCOUNT VARIATION DETAILS (Record account variation changes on PHI(2) form)
 CHARGEABLE STATUS
 1. Public 2. Private Shared 3. Private Single
 COMPENSABLE STATUS
 1. Workers' Compensation (Old) 2. Workers' Compensation (Other) 3. Compensable Third Party
 4. Other compensable 5. Dept of Veterans' Affairs 6. Motor Vehicle (Old)
 7. Motor Vehicle (Other) 8. None of the above 9. Dept of Defence

PATIENT LEAVE DETAILS (Record additional leave details on PHI(2) form)
 DATE OF STARTING LEAVE _____ TIME OF STARTING LEAVE _____
 DATE RETURNED FROM LEAVE _____ TIME RETURNED FROM LEAVE _____

TREATING DOCTOR _____

SIGNATURE _____ DATE _____
 Any extra morbidity codes, activity details or mental health details (Y or N), complete and attach PHI (2).
 Any SNAP details (Y or N), complete and attach PHI (3).

ICU - LENGTH OF STAY Time (hhhhmm) _____
 CONTINUOUS VENTILATION Time (hhhhmm) _____

CONGENITAL ANOMALIES FETUS NUMBER
 1. Singleton or first of a multiple pregnancy 2. Second of a multiple pregnancy
 3. Third of a multiple pregnancy 4. Fourth of a multiple pregnancy
 5. Fifth of a multiple pregnancy 6. Sixth of a multiple pregnancy
 7. Seventh of a multiple pregnancy 8. Eighth of a multiple pregnancy
 9. Ninth of a multiple pregnancy 10. Tenth of a multiple pregnancy

ICD CODE _____

ABORTION TYPE
 1. Missed abortion 2. Medical termination
 3. Surgical termination 4. Feticide 9. Not applicable

FAMILY NAME _____

GIVEN NAMES _____

ADDRESS OF USUAL RESIDENCE
 No. and Street _____
 Suburb/town _____
 Postcode _____ State _____

DATE OF BIRTH _____ Estimated DOB 1. Yes

MARITAL STATUS
 1. Never Married 3. Widowed 5. Separated
 2. Married (registered and de facto) 4. Divorced 9. Not stated/unknown

COUNTRY OF BIRTH _____

INDIGENOUS STATUS
 1. Aboriginal but not Torres Strait Islander origin
 2. Torres Strait Islander but not Aboriginal origin
 3. Both Aboriginal and Torres Strait Islander origin
 4. Neither Aboriginal nor Torres Strait Islander origin 9. Not Stated / Unknown

AUSTRALIAN SOUTH SEA ISLANDER
 1. South Sea Islander Origin 9. Not stated/unknown
 2. Non South Sea Islander Origin

SEX
 1. Male
 2. Female
 3. Other

BABY ADMISSION WEIGHT (where <2500g or <29 days) _____

FUNDING SOURCE
 01. Health Service Budget (not covered elsewhere)
 02. Private health insurance
 03. Self-funded
 04. Worker's compensation
 05. Motor vehicle third party personal claim
 06. Other compensation
 07. Department of Veterans' Affairs
 08. Department of Defence
 09. Correctional facility
 10. Other hospital or public authority (contracted care)
 11. Health Service Budget (due to eligibility for Reciprocal Health Care Agreement)
 12. Other
 13. Health Service Budget (no charge raised due to hospital decision)
 99. Not Known

HOSPITAL INSURANCE
 7. Hospital Insurance 8. No hospital insurance 9. Not stated/unknown

BAND _____ CONTRACT ROLE A = Hosp A, B = Hosp B _____ CONTRACT TYPE 1=B, 2=ABA, 3=AB, 4=(A)B, 5=BA

- Code purchaser if contract type = 1, contract role = B and public chargeable status
 - Code the other hospital identifier if contract type = 2, 3, 4 or 5 and contract role A or B

PURCHASER/PROVIDER IDENTIFIER _____

MEDICARE ELIGIBILITY
 1. Eligible 2. Not Eligible 3. Not stated/unknown

MEDICARE NUMBER _____

DVA PATIENT DETAILS (Where compensable status = 5)
 DVA FILE NUMBER _____

CARD TYPE G = Gold W = White

QUALIFICATION STATUS _____ (Record qualification status changes on PHI(2) form)
 A = Acute U = Unqualified

CONTRACT LEAVE DETAILS
 Complete table when patient transferred for contract service at another hospital

DATE TRANSFERRED FOR CONTRACT	DATE RETURNED FROM CONTRACT	FACILITY NUMBER CONTRACTED TO
_____	_____	_____
_____	_____	_____

MORBIDITY CODES (e.g. ICD-10-AM)
 PD - Principal Diagnosis
 OD - Other Diagnosis
 M - Morphology
 EX - External Cause
 PR - Procedure

CONTRACT FLAG (CF) (if applicable)
 1. Contracted admitted procedure
 2. Contracted non-admitted procedure

DIAGNOSIS ONSET TYPE (COF)
 1. Condition present on admission to the episode of care
 2. Condition arises during the episode of care

ICD TYPE	ICD CODE	PROCEDURE DATE	CF	COF
1. P D	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____

Record additional morbidity codes on the PHI(2) form.

A F F I X P A T I E N T L A B E L

HOSPITAL IDENTIFICATION AND DIAGNOSIS FORM PHI (1)

JULY 2020

PATIENT ACTIVITY PAGE

U.R. NUMBER

ADMISSION DATE

SURNAME

GIVEN NAME(S)

FACILITY

ADMISSION NUMBER

ADMISSION TIME (0000 - 2359)

SEX 1. Male 2. Female 3. Other

DATE OF BIRTH

EXTRA MORBIDITY CODES

OD - Other Diagnosis, M - Morphology, EX - External Cause, PR - Procedure

CONTRACT FLAG (CF) (if applicable)

1. Contracted admitted procedure 2. Contracted non-admitted procedure

DIAGNOSIS ONSET TYPE (COF)

1. Condition present on admission to the episode of care
2. Condition arises during the episode of care

CONGENITAL ANOMALIES

FETUS NUMBER ICD CODE

1. Singleton or first of a multiple pregnancy
2. Second of a multiple pregnancy
3. Third of a multiple pregnancy
4. Fourth of a multiple pregnancy
5. Fifth of a multiple pregnancy
6. Sixth of a multiple pregnancy

ABORTION TYPE

1. Missed abortion
2. Medical termination
3. Surgical termination
4. Feticide
9. Not applicable

	ICD TYPE	ICD CODE	PROCEDURE DATE	CF	COF		ICD TYPE	ICD CODE	PROCEDURE DATE	CF	COF
11.						20.					
12.						21.					
13.						22.					
14.						23.					
15.						24.					
16.						25.					
17.						26.					
18.						27.					
19.						28.					

WARD DETAILS - Complete the fields below for any additional admission or standard ward/unit transfers

ADMISSION WARD	ADMISSION UNIT	STANDARD UNIT CODE	STANDARD WARD CODE	DATE OF TRANSFER (0000-2359)	TIME OF TRANSFER
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PATIENT LEAVE DETAILS - Complete table every time patient goes on leave

DATE OF STARTING LEAVE	TIME OF STARTING LEAVE	DATE RETURNED FROM LEAVE	TIME RETURNED FROM LEAVE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

CONTRACT LEAVE DETAILS - Complete table when patient transferred for contract service at another hospital.

DATE TRANSFERRED FOR CONTRACT	DATE RETURNED FROM CONTRACT	FACILITY NUMBER CONTRACTED TO
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

ACCOUNT VARIATION CHANGE DETAILS

CHARGEABLE STATUS CHANGE	DATE OF CHANGE	COMPENSABLE STATUS CHANGE	DATE OF CHANGE
1. Public <input type="checkbox"/>	<input type="text"/>	1. Workers' Compensation (Qld) <input type="checkbox"/>	<input type="text"/>
2. Private Shared <input type="checkbox"/>	<input type="text"/>	2. Workers' Compensation (Other) <input type="checkbox"/>	<input type="text"/>
3. Private Single <input type="checkbox"/>	<input type="text"/>	3. Compensable Third Party <input type="checkbox"/>	<input type="text"/>
		4. Other compensable	
		5. Dept of Veterans' Affairs	
		6. Motor Vehicle (Qld)	
		7. Motor Vehicle (Other)	
		8. None of the above	
		9. Dept of Defence	

QUALIFICATION STATUS CHANGE DETAILS

QUALIFICATION STATUS
A = Acute U = Unqualified

QUALIFICATION STATUS	DATE OF CHANGE
<input type="checkbox"/>	<input type="text"/>
<input type="checkbox"/>	<input type="text"/>

MENTAL HEALTH DETAILS - Required for all admitted episodes where the standard unit code is in the range PYAA to PYZZ (Mental Health Unit).

TYPE OF USUAL ACCOMMODATION <input type="checkbox"/>	REFERRAL TO FURTHER CARE <input type="text"/>
EMPLOYMENT STATUS <input type="checkbox"/>	MENTAL HEALTH LEGAL STATUS INDICATOR <input type="text"/>
PENSION STATUS <input type="checkbox"/>	PREVIOUS SPECIALISED NON-ADMITTED TREATMENT <input type="text"/>
FIRST ADMISSION FOR PSYCHIATRIC TREATMENT <input type="checkbox"/>	

NURSING HOME TYPE PATIENT DETAILS

START DATE	END DATE
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

PALLIATIVE CARE DETAILS (where care type is 30)

FIRST ADMISSION FOR PALLIATIVE CARE TREATMENT

1. No previous admission for palliative care treatment
2. Previous admission for palliative care treatment

PREVIOUS SPECIALISED NON-ADMITTED PALLIATIVE CARE TREATMENT

1. No previous non-admitted service contact for palliative care treatment
2. Previous non-admitted service contact(s) for palliative care treatment

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HOSPITAL IDENTIFICATION AND DIAGNOSIS FORM - ACTIVITY PAGE PHI (2) JULY 2020