

Discharge Services Notification Information Sheet

Helping a person to discharge from hospital and return to their community safely and effectively provides a foundation for positive adjustment and helps build participant/worker confidence in the support services available to them. The discharge process is collaborative and multi-faceted, requiring careful organisation and frequent communication between the hospital unit, participant/worker, their family, icare and service providers.

The Discharge Services Notification form (DSN)

The DSN sets out the services required for a participant/worker during the first 16 weeks after discharge from hospital. The DSN is completed by the inpatient team if the person is in hospital or by the case manager if they are in the community. The completion of the DSN is supported by the nominated icare contact in collaboration with the participant/worker and their family.

Completing the DSN

Completing the DSN should start as early as possible to allow for adequate assessments and referrals to be arranged. It is the responsibility of the inpatient team / case manager to check provider capacity and suitability (skills, registration, specialty) and acceptance of new referrals. Completing the DSN is a team effort that requires effective collaboration. If you have any questions about the DSN or need assistance during the discharge planning process, speak with the participant/worker's nominated icare contact as early as possible.

Where possible, the DSN should be completed and submitted to icare 2 to 4 weeks prior to discharge.

There are separate DSN forms for adults and children, which are available on our website - Lifetime Care: [Lifetime Care | icare](#) and Workers Care: [Workers Care | icare](#)

Complete the pre-approved services and non pre-approved services list as comprehensively as possible. This includes:

- hourly rates for providers and quotes for other services
- travel and/or report writing if required
- specifying providers - icare is unable to approve providers listed as "TBA"
- justification for any hours requested above the nominated pre-approved hours

Additional information that may impact on discharge

Home/destination

If there are concerns around the home environment impacting a person's ability to discharge, a home assessment must be arranged. The assessment should be conducted by the inpatient occupational therapist or a designated external occupational therapist (where distance is a factor). If home modifications are required, a Discharge Destination Form needs to be completed as early as possible.

Care need

If there is a predicted care need post discharge, a Care Needs Assessment Report (CNAR) is required. This can be completed by the hospital's nominated assessor or in certain circumstances (where a hospital assessor is not available) an external care needs assessor may be allocated. This will be arranged by icare.

Where attendant care is required, an Attendant Care Service Request (ACSR) will also need to be completed and submitted to icare. The inpatient team should investigate approved attendant care panel provider suitability

and capacity, ensuring that a panel provider can be appointed as soon as possible. icare has an [attendant care finder tool](#) to assist with this process. The participant/worker and their family should be involved in the choice of care providers where appropriate. Please discuss with the person's nominated icare contact.

Equipment

If a participant/worker needs equipment for a safe discharge, this should be coordinated by the inpatient team, ensuring delivery occurs prior to discharge. It is recommended to hire equipment where possible, as changes are often required after discharge.

When requesting equipment, please note:

- prescribing occupational therapists and physiotherapists must be registered for the Equipment Panel Providers Portal
- the prescribing therapist must submit requests for equipment on the Equipment Request Form (when not requested through Easy Order or Portal Order)
- equipment should be hired or purchased from the Equipment Panel Providers in the first instance, unless there is demonstrated evidence that the panel providers are unable to meet the needs of the participant/worker.

Cultural factors

Depending on the resources and services available, cultural considerations should be explored as part of the discharge planning process to ensure that, where possible, clinical referrals are culturally appropriate. For example, a participant/worker who identifies as a First Nations person may have engaged with an Aboriginal Liaison Officer (ALO) and have planned to link with culturally appropriate services in the community.

Handover

Handover to community-based therapists needs to occur prior to discharge for each discipline so that treatment and care is seamless for the participant/worker. A copy of discharge summary from the hospital/rehab unit must be provided to icare.

Submitting the DSN for approval

Once the DSN is complete, submit the form to icare following the instructions on the form and include any reports, summaries and additional information.

Once submitted, icare will review the DSN and supporting documents and contact the discharge planner to discuss the next steps.

Forms and resources

Lifetime Care: [Lifetime Care | icare](#)

Workers Care: [Workers Care | icare](#)

Equipment Portal: [Equipment requests | icare](#)

Equipment Panel Providers: [Equipment Panel | icare](#)

Attendant Care: [attendant care finder tool](#)

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