

INVOICE REQUIREMENTS (Must include referral reference # provided by Quinte Health)	
Bill to: Quinte Health 265 Dundas Street East Belleville, ON K8N 5A9 Attention: Accounts Payable Invoices can be submitted via the following options: 1. Email to ap@qhc.on.ca bundledarthroplasty@qhc.on.ca *All emailed client information must be secure and password protected* 2. By Fax to: 613-961-2506	Patient Name: Date of Birth: Health Card Number with version code:

To bill for bundle rehab services provided, the pathway must be completed with patient having met goals or transferred to another provider (must include that detail). Once the patient has been discharged from your services and within 30 days of discharge, please send all documents (invoice/service discharge summary and if necessary the completed Electronic Funds Transfer Form) to the FAX or email above.

1. One invoice per patient
2. One Discharge Summary form per patient
3. Electronic Funds Transfer Form (if first invoice to our hospital)

The clinic must complete the NACRS Clinic Lite data reporting tool for this patient. More information can be found at: <https://www.cihi.ca/en/nacrs-clinic-lite>

Patient Reported Outcome Measures (PROMS): upon discharge from your rehab clinic the patient is to be reminded to complete their 3-month and 1-year PROMS survey online.

For all invoice processing inquiries and questions please email: bundledarthroplasty@qhc.on.ca

DETAIL		TOTAL
<input type="checkbox"/>	Hip/Knee Bundled Care Post-Acute Rehabilitation Program	\$312
<input type="checkbox"/>	Shoulder Bundled Care Post-Acute Rehabilitation	\$486

Invoice Date: _____
 (DD/MM/YY)

Total Due _____

DISCHARGE SUMMARY FORM

HEALTH CARD # _____

PROCEDURE PERFORMED: Hip Knee Shoulder
 Left Right

NAME OF FACILITY: _____

ADDRESS OF FACILITY: _____

MOHLTC FACILITY # _____

DATE OF INITIAL ASSESSMENT: _____ DATE OF DISCHARGE: _____
(DD/MM/YY)

NUMBER OF COMPLETED SESSIONS: _____ NACRS CLINIC LITE COMPLETED: _____

PROMS REMINDER TO PATIENT: _____

FORMAT OF SESSIONS: GROUP-BASED 1:1

DISCHARGE CRITERIA		
TOTAL KNEE	TOTAL HIP	TOTAL SHOULDER
<p>*Please check box if criteria was met</p> <p>Functional active ROM (consider pre-op status)</p> <p><input type="checkbox"/> 0-5 degrees Knee Extension <input type="checkbox"/> 110 degrees Knee Flexion</p> <p>Functional Strength (consider pre-op status)</p> <p><input type="checkbox"/> Knee: Grade 4/5 or functional control of the knee <input type="checkbox"/> Quadriceps strength without lag in straight leg raise (SLR) and short arch quadriceps (SAQ) sitting</p> <p>Pain (consider pre-op status and co-morbidities)</p> <p><input type="checkbox"/> Manageable pain with functional activities of daily living <input type="checkbox"/> Swelling resolved or self-managed; wound healed or self-managed</p> <p>ADLS</p> <p><input type="checkbox"/> Independent ambulation (indoors and outdoors), With/without ambulation aid as required – consider pre-op status) <input type="checkbox"/> Normal, reciprocal gait pattern (consider pre-op status and co-morbidities) <input type="checkbox"/> Safe transfers as required (home, vehicle) <input type="checkbox"/> Safe use of stairs if required</p> <p><input type="checkbox"/> Discharged with home exercise program</p>	<p>*Please check box if criteria was met</p> <p>Functional active ROM</p> <p><input type="checkbox"/> Flexion minimum 90 degrees (hip)</p> <p>Functional Strength</p> <p><input type="checkbox"/> Hip: Grade 4/5 hip flexion and extension <input type="checkbox"/> Grade 4/5 hip abduction</p> <p>Pain (consider pre-op status and co-morbidities)</p> <p><input type="checkbox"/> Manageable pain with functional activities of daily living <input type="checkbox"/> Swelling resolved or self-managed; wound healed or self-managed; pain self-managed</p> <p>ADLS</p> <p><input type="checkbox"/> Independent ambulation (indoors and outdoors, with/without ambulation aid as required-consider pre-op status) <input type="checkbox"/> Normal reciprocal gait pattern (consider pre-op status and co-morbidities) <input type="checkbox"/> Safe transfers as required (home, vehicle) <input type="checkbox"/> Safe use of stairs if required</p> <p><input type="checkbox"/> Discharged with home exercise program</p>	<p>*Please check box if criteria was met</p> <p>Functional Strength and ROM</p> <p><input type="checkbox"/> As per patients functional goals</p> <p>Pain (consider pre-op status and co-morbidities)</p> <p><input type="checkbox"/> Manageable pain with functional activities of daily living <input type="checkbox"/> Swelling resolved or self-managed; wound healed or self-managed; pain self-managed</p> <p>ADLS</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Discharged with home exercise program</p>
<p>Notes/Comments/Other Considerations</p>		