OCCUPATIONAL PHYSIOTHERAPY: TREATMENT NOTIFICATION PLAN

Privacy

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information.

Without this information, the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment.

Please refer to the notes for assistance in completing this form

Client details

Client name

Claim no.

Date of birth / /

Date of accident / /

Client occupation

Referred by

Referrer telephone no.

1. Current work status ☐ Normal duties ☐ Modified duties ☐ Not working ☐ Not employed pre accident

Is client likely to be discharged within 12 weeks? ☐ Yes ☐ No *Please tick reason* ☐ *Physical factors* ☐ *Non physical factors*

2. Had this client attended your practice prior to the accident? ☐ Yes ☐ No *If yes, please specify condition and what treatment period*

3. Specific anatomical site of accident injuries and clinical diagnoses

4. Current reported symptoms and physical assessment findings

5. Provide details of relevant standardised outcome measures (SOM) used, date administered and initial assessment score(s)

Date administered	SOM(s)	Score(s)
/ /		
/ /		

6. List current activity/functional limitations and related goals

Current activity/functional limitations	Short term activity goals *include ADL and work/travel goals*	Estimated date of achievement
1.	1.	/ /
2.	2.	/ /
3.	3.	/ /
4.	4.	/ /

7. Proposed treatment plan *from today's date*

Total no. of services ____ over ____ weeks from / / to / /

8. Proposed treatment methods

☐ In rooms physiotherapy ☐ Supervised exercise program ☐ Supervised hydrotherapy ☐ Other *specify* _____

9. List the education and self management strategies to be implemented by client/carer

Provider details

Provider name, address and phone no. *Use practice stamp where possible*

Signature

Days/hours available

Date / /

Client authorisation

I have discussed this treatment plan with my physiotherapist and I consent for my physiotherapist to supply the TAC with the information requested above and to discuss this with members of the TAC Clinical Panel as required.

Signature of client, parent or guardian

Print name

Date / /

All questions must be answered for this plan to be considered. Please use block letters and attach any information that may be relevant.

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