**Allied health  
recovery request**

For use with NSW CTP personal injury and workers compensation injury claims.

| AHRR number |  | Date of request (DD/MM/YYYY) |
| --- | --- | --- |
|  |  |  |

Physiotherapist Psychologist Counsellor Osteopath Chiropractor

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Accredited exercise physiologist Other: | | |  | |
| Referred by (where relevant) |  | | Phone number |
|  |  | |  |

# Section 1: Client details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Client name | | | | |
|  | | | | |
| Date of birth (DD/MM/YYYY) |  | Phone number |
|  |  |  |

## Claim information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Insurer | | | | |
|  | | | | |
| Claim number |  | Date of injury/accident (DD/MM/YYYY) |
|  |  |  |

# Section 2: Clinical assessment

|  |
| --- |
| Diagnosis |
|  |

Have you liaised with the treating medical practitioner? Yes No

Is your diagnosis consistent with the medical practitioner’s diagnosis of the compensable injury?

Yes Unknown No (if no, please provide details in the last box in section 2)

Clinical assessment continued over

|  |  |  |
| --- | --- | --- |
| Current signs and symptoms – include reported/observed and relevant objective measures | | |
|  | | |
|  | | |
| Details of any pre-existing factor(s) directly relevant to the compensable injury. | |
|  | |

|  |  |
| --- | --- |
| Details of any other providers treating the client and whether you have liaised with them. | |
|  | |

**Workers compensation:** Do you have a copy of the position description/work duties?

Yes No If no, contact the insurer

# Section 3: Capacity

|  | **Pre-injury capacity**  (describe what the client did before the injury(s) related to this claim) | **Capacity at initial assessment or last AHRR**  (whichever is most recent) | **Current capacity**  (describe what the client can do now) |
| --- | --- | --- | --- |
| **Work** (occupation, tasks, days/ hours worked) |  |  |  |
| **Home** (self care, domestic, caring) |  |  |  |
| **Community** (driving, transport, leisure) |  |  |  |

|  |
| --- |
| **Are there any factors that have impacted on progress since treatment commenced or may impact on future recovery? If so, what are your recommendations to address these barriers** (specific management strategies, referral to other services)? |
|  |

# Section 4: Recovery plan

|  |  |  |
| --- | --- | --- |
| Date your services first commenced (DD/MM/YYYY) |  | Number of sessions provided to date |
|  |  |  |
| AHRR start date (DD/MM/YYYY) |  | AHRR end date (DD/MM/YYYY) |
|  |  |  |

GOALS: must focus on work or functional outcomes to provide the direction for treatment and recovery and may carry over more than one AHRR. They must also be SMART.

|  |  |
| --- | --- |
| **CLIENT GOAL 1** |  |

STEPS: are activities/behaviours the client needs to be able to do to achieve their goal. The steps and actions listed are intended to be achieved in this AHRR period.

| **Client steps** (to achieve in this AHRR period) | **Client action plan** (self management strategies) | **Service provider’s action plan** |
| --- | --- | --- |
|  |  |  |

|  |  |
| --- | --- |
| **CLIENT GOAL 2** |  |

STEPS: are activities/behaviours the client needs to be able to do to achieve their goal. The steps and actions listed are intended to be achieved in this AHRR period.

| **Client steps** (to achieve in this AHRR period) | **Client action plan** (self management strategies) | **Service provider’s action plan** |
| --- | --- | --- |
|  |  |  |

This request was completed in consultation with the client who agreed to the recovery plan:

|  |  |  |
| --- | --- | --- |
| Yes No | Date (DD/MM/YYYY) |  |

# Section 5: Services requested

| **Service type** (include consultation type and other services – eg aids/equipment) | **Number of sessions** | **Frequency/timeframe** (eg 1 x week for six weeks) | **Service code** (if applicable) | **Unit cost/specify** | **Total** |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  | | | | |  |

If you wish to add another service type, right click on the last full row in the table and select ‘Insert/Insert rows below’.

| **Case conferencing only** | **Number of hours** | **Frequency/timeframe** | | **Service code** (if applicable) | **Unit cost/specify** | **Total** |
| --- | --- | --- | --- | --- | --- | --- |
| Case conferencing |  |  | |  |  |  |
|  | | | | | | |
|  | | | **Overall total** (total of all cells above) | | |  |

|  |
| --- |
| **Workers compensation:** Would you like the assistance of an Independent Consultant? Yes No |

| **Rationale for services requested** (include/attach additional information to assist insurer decision making) | | |
| --- | --- | --- |
|  | | |
| Anticipated date of discharge (DD/MM/YYYY) |
|  |

# Section 6: Service provider details

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service provider name | | | | | | | | | | |
|  | | | | | | | | | | |
| Practice name | | | | | | | | | | |
|  | | | | | | | | | | |
| Suburb | | | | | |  | State |  | Postcode | |
|  | | | | | |  |  |  |  | |
| Phone number | | |  | Fax number | | | | | | |
|  | | |  |  | | | | | | |
| Email | | | | | | | | | | |
|  | | | | | | | | | | |
| Best time/day to contact | |  | SIRA (formerly known as WorkCover) workers compensation approval number (if relevant) | | | | | | | |
|  | |  |  | | | | | | | |
|  | |  | **Note:** All SIRA approved practitioners must ensure their contact details with SIRA are up to date. Email your current details to [compliance.info@sira.nsw.gov.au](mailto:compliance.info@sira.nsw.gov.au) | | | | | | | |
| Signature | |  | Provider stamp (if available) | | | | | | | |
|  | |  |  | | | | | | |

# Section 7: Insurer decision

Approved Declined Partially approved

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Workers compensation:** An Independent Consultant review to be arranged: | | | | | | Yes No | | | |
| If declined or partially approved please provide reasons | | | | | | | | | |
|  | | | | | | | | | |
| Decision maker’s name | | |  | | Phone number | | | |
|  | | |  | |  | | | |
| Signature | |  | Date (DD/MM/YYYY) | | | | |
|  | |  |  | | | |
|  |  | | | |

**Please forward the completed AHRR to the relevant insurer.**

**CC: treating medical practitioner and other treatment practitioners where involved.**

Catalogue No. **SIRA08033\_Word**  
State Insurance Regulatory Authority  
Customer Experience 13 10 50 | Website [www.sira.nsw.gov.au](http://www.sira.nsw.gov.au/)  
© Copyright State Insurance Regulatory Authority 0518