DRAFT Allied health treatment request

State Insurance Regulatory Authority

For use with NSW motor accidents (CTP) and workers compensation (WC) injury claims. All sections are to be completed.

Health care practitioners should deliver services according to the principles outlined in the *Clinical Framework for the Delivery of Health Services* (Clinical Framework). The treatment request is an important communication tool that requires allied health practitioners to demonstrate they are adopting the principles of the Clinical Framework in the treatment of the person's injuries.

Request number: ☐ **Date of request:** DD/MM/YYYY
This is the number of request forms submitted

Date services first commenced: DD/MM/YYYY **Total number of consultations to date**: ☐

Physiotherapist ☐	Psychologist ☐	Chiropractor ☐	Counsellor ☐
Accredited Exercise Physiologist ☐	Osteopath ☐	Other ☐ Specify:	
Referred by:		Phone number:	

Section 1: Injured person details

PERSONAL	
Name:	Date of birth: DD/MM/YYYY
Pre-injury occupation:	Pre-injury work hours/week (average):
CLAIM	
Claim number:	Date of injury/accident: DD/MM/YYYY

Section 2: Your clinical assessment

COMPENSABLE INJURY
Diagnosis and/or specific area/s being treated:
Current signs and symptoms:
Details of any pre-existing factor(s) directly relevant to the compensable injury:

OBJECTIVE MEASURES At least two measures should be reported

Standardised outcome and/or risk screening measures	Initial score		Subsequent score		Next subsequent score		Latest score	
	Date	Score	Date	Score	Date	Score	Date	Score
e.g. Neck Disability Index (NDI) Keele STarT Back Screening Tool	1/6/22 1/6/22	36/50 6/9					15/6/22 15/6/22	24/50 4/9

CAPACITY
In my opinion, the person has capacity for work (if relevant) for _____ hours/day _____ days/week

Section 3: Issues/risks to progress

Issues/risks identified by assessment, objective measures and risk screening that may impact recovery and return to work:
Strategies to address issues/risks (include actions taken by you and any recommendations for the insurer):
If previous goals were not met, provide any additional relevant information/explanation:
Would you like to discuss the recovery of the injured person with an independent consultant? (WC only) ☐Yes
Is current medication an issue/risk? ☐Yes ☐No If yes, explain why:

Section 4: Your recommended recovery plan

Do you have a copy of the position description/work duties (WC and where relevant CTP) ☐Yes ☐No If no, insurer to provide.

Injured person goals (SMART) e.g. To return to my usual job as a retail assistant by 4 August; To drive for an hour to my parent's home by 6 July; To return to training my kid's soccer team by 3 October.		**Est. date of achievement**
1. Work (if applicable) or activity goal	To … by…	DD/MM/YYYY
2. Activity goal	To … by…	DD/MM/YYYY
Injured person's self-management (what techniques/strategies or exercises are they completing between sessions?):		
Provider intervention:		
This recovery plan was developed with the injured person: ☐Yes ☐No		
Start date of this plan: DD/MM/YYYY	**End date of this plan:** DD/MM/YYYY	
Anticipated total number of sessions prior to discharge: ☐	**Anticipated discharge date:** DD/MM/YYYY	

Section 5: Services you are requesting

Service type include consultation type and other services e.g. aids/equipment	**Number of sessions**	**Frequency/timeframe** e.g. 1 x week for 6 weeks	**Service code** where applicable	**Unit cost**	**Total cost**
Case conferencing	**Number of hours**	**Frequency/timeframe**	**Service code** where applicable	**Unit cost**	**Total cost**
				Overall total	
Rationale for services requested:					

Section 6: Your details

Service provider's name:		SIRA WC approval number (if relevant)	
Practice name:			
Suburb:		State:	Postcode
Phone number:	Email:		Fax:
Signature:			

Section 7: Insurer decision

☐ Approved	☐ Approval of some services only	☐ Declined	☐ More information required
An explanation *must* be provided below if the insurer's decision is 'Approval of some services only', 'Declined' or 'More information required'. Insurers note: you must provide additional documentation about the decision to decline any services in line with legislative obligations, including where requesting more information			
Explanation:			
An independent consultant review is to be arranged (WC): ☐Yes ☐No			
Contact name:	Phone number:	Email:	
Signature:	Date:		