**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 beforethe injury(s) related to this claim) | **Capacity at initial assessmentor 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 ofsessions** | **Frequency/timeframe**(eg 1 x week for six weeks) | **Service code**(if applicable) | **Unitcost/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 ofhours** | **Frequency/timeframe** | **Service code**(if applicable) | **Unitcost/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 |
| 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.**

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