Allied health recovery request

State Insurance Regulatory Authority

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)

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)?

Client name Claim number AHRR number

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:

Date (DD/MM/YYYY)

Yes No

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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**

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

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

Practice name

Suburb State Postcode

Phone number Fax number

Email Best time/day to contact

Signature Provider stamp (if available)

Client name Claim number AHRR number

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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