

ACC32 Number: 7877123e.0001

SECTION 1: CLAIMANT'S DETAILS

ACC45 Number :
Claimant's Name :
Date of Birth :
Claimant's Address :

Date of Injury:

Occupation :

Telephone:

SECTION 2: TREATMENT DETAILS

Read Code(s): S461.00
No. of Treatments given to date: 0

Treatment Profile recommended no. of treatments:
No. of Additional Treatments requested: 1

SECTION 3: PROVIDER DETAILS

Provider Name :
Address :

Provider Type:
ACC Provider No.: 7877123

Phone:

SECTION 4: HISTORY, EXAMINATION AND DIAGNOSIS

Initial Diagnosis:

Mechanism of injury (as described by patient):

Current diagnosis (include a precise description of the current condition):

Clinical reasoning as to how the initial personal injury covered by ACC is the primary contributing factor to the current condition (e.g. continuation of initial treatment):

Factors contributing to treatment being exceeded or non-resolution of this injury (eg. post surgical complications, patient non-compliance or age-related factors, degenerative changes):

SECTION 5: PROPOSED MANAGEMENT AND PROGNOSIS

Current functional & clinical limitations and overall functional goal of treatment (eg. how is the injury affecting the claimant's independence or ability to work and details of work activities affected):

Functional Goals (specific and measurable)	Treatment Plan	Expected timeframe to achieve outcomes

Please note or attach any referral information:

Recommendations for other interventions, if any, that would consider referring to if not achieving treatment goals (eg. pain management, surgery, etc.):

SECTION 6: CERTIFICATE AND SIGNATURE

This treatment is for the personal injury for which the claimant has cover and:

- is for the purpose of restoring the claimant's health to the maximum extent practicable, and
- the treatment is necessary and appropriate, and of the quality required, for that purpose.

I have discussed the treatment options with the claimant and advised why the recommendation is the appropriate treatment in this case.

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REQUEST FOR APPROVAL OF ADDITIONAL TREATMENT

Provider's signature: _____ Date: _____

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The information collected on this form will only be used to fulfill the requirements of the Injury Prevention, Rehabilitation, and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code 1994.