**Visit**  Initial visit  Follow-up/subsequent visit

**Discipline**  Physiotherapy  Osteopathy  Chiropractic  Exercise physiology  Podiatry  Acupuncture  Dietetics  Hand therapy

## Client details

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client name |  | Claim number |  | Date of accident |  | Date of birth |  | Occupation |
|  |  |  |  | / / |  | / / |  |  |

**Current work status**  Normal duties  Modified duties  Not working  Not applicable

## Injury details Diagnosis and specific areas being treated

|  |
| --- |
|  |

## Outcomes Standardised outcome measures

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Outcome measure | Initial score | | Subsequent score | | Next subsequent score | | Latest score | |
| Date | Score | Date | Score | Date | Score | Date | Score |
|  | / / |  | / / |  | / / |  | / / |  |
|  | / / |  | / / |  | / / |  | / / |  |

## Screening of psychosocial risk factors (barriers) to recovery

|  |  |  |  |
| --- | --- | --- | --- |
| Psychosocial screening tool | Date | Score | Actions taken |
|  | / / |  |  |

*(e.g. Ӧrebro short form – see notes page)*

**Issues/risks identified that may impact recovery and return to work, if any** List barriers you’ve recognised and steps you’ve taken or will be taking to address

|  |
| --- |
|  |

## Goals of your treatment List current activity/functional limitations and related goals that your treatment will address

|  |  |  |
| --- | --- | --- |
| Current activity / functional limitations | Short-term activity goals (Include ADL and work/travel goals) | Estimated date of achievement |
| 1. |  | / / |
| 2. |  | / / |
| 3. |  | / / |
| 4. |  | / / |

## Treatment strategies

|  |
| --- |
|  |

**Self-management strategies** Include an itemised list of all therapy support items you have provided to the client to assist with their rehabilitation needs.

|  |
| --- |
|  |

## Proposed treatment plan Anticipated discharge date

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Total no. of services |  | over |  | weeks from | / / | to | / / |  | / / |

## Treating practitioner details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Provider name, employer, address and phone (*Use practice stamp where possible)* |  | Treating practitioner’s signature *(Insert jpg/png of signature or print and sign by hand)* | | |
|  |  |  | | |
|  |  | | |
|  | Availability for discussion |  | Date |
|  |  |  | / / |

## Acknowledgement

I have discussed this treatment plan with my patient and I agree to discuss this plan with members of the TAC Clinical Panel as required. I understand that I can only bill the TAC for treatment that is directly related to my patient’s transport accident.

## Privacy

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [tac.vic.gov.au](https://www.tac.vic.gov.au)