Provider Treatment Plan – Psychological

☐ Initial Plan ☐ *Subsequent Plan

Please forward the completed treatment plan, copies of medical referrals / correspondence and outcome measures to the relevant insurer. Visit www.maic.qld.gov.au for a guide to completing treatment plans.

Claimant Details

Claimant Name	Claim Number	Insurer Name	Insurer Fax	Referrer Name	Referrer Telephone

Reason for referral

Treatment Plan No	Date of Accident (dd/mm/yyyy)	Initial Consult Date	Number of unpaid previous sessions	Numbers of sessions to date

***Relevant mental health history** *(details of any relevant mental health problems or treatment, including medication, prior to MVA)*

Pre-MVA Work Status

☐ Full-time ☐ Part-time ☐ Not working prior to MVA Pre-injury occupation:

Current Work Status

☐ Full-time ☐ Part-time ☐ Not returned to work ☐ Not RTW but work ready ☐ N/A – *Skip next question*

Current Work Duties

☐ Normal Duties ☐ Modified Duties ☐ Reduced Hours

Comments:

Current clinical findings *(including symptoms, frequency of occurrence, effect on function)*

***Test results/outcome measure results** *(for baseline and comparative purposes)*

Date (dd/mm/yyyy)	Psychological tests	Test scores and summary analysis

* If completing a subsequent plan, there is no need to repeat information written in previous plan.

***Current diagnosis** *(reference to DSM 5)* *If subsequent plan: has current diagnosis changed since previous plan?*	☐ Yes ☐ No		
Assessment Categories	Mental Disorder Diagnostic and Functional Information	Approximate date of onset (dd/mm/yyyy)	Relationship to MVA: 1. Causally related 2. Unrelated 3. Exacerbation of pre-existing condition 4. Late onset
Clinical Diagnosis (incl personality disorder/ intellectual impairment)			
General Medical Conditions impacting on management of the mental disorder			
Psychosocial and Environmental Issues (ICD 10 Z codes)			
Disability e.g. WHODAS score			

Additional comments regarding diagnosis *(e.g. is a diagnosis provisional or is there a differential diagnosis?)*

Risk factors and appropriate treatment strategies relevant to the claim *(Note: risk factors that may pose barriers to return to social and occupational roles e.g. compliance with treatment, severity of problem, previous treatment failure, severity of pre-morbid condition)*

Treatment Progress

Target problem (please describe in order of priority – most significant first)	Treatment goals	Treatment method	Progress to goal attainment

Details of treatment proposed: *(Treatment goals should include specific functional outcomes, be measurable and agreed to by the claimant)*

Target problem (please describe in order of priority – most significant first)	Treatment goals (inc. functional goals)	Treatment method	Measures to be used	Review date (dd/mm/yyyy)

Proposed treatment: ______ sessions, over ______ weeks at $ ______ per session

Prognosis:

Has there been liaison with the claimant’s treating medical or allied health providers? ☐ Yes ☐ No

Additional comments:

Provider Name:				**INSURER USE ONLY**			
Qualifications:				Funding approved: ☐ Yes ☐ No† ☐ Partial†			
Practice Name:				Details/comments:			
Practice Address:							
Email:				Insurer Signature:		Date:	
Phone:		Fax:		Name:			
Signature:		Date:		† Insurer will provide written explanation if plan is partially/not approved			

* If completing a subsequent plan, there is no need to repeat information written in previous plan.