Treatment plan no: _____

PROVIDER TREATMENT PLAN – PHYSICAL

Insurer name:	Insurer fax number:
Claimant's name:	Claim number:
Date of accident:	No. of sessions to date:
Date of initial consult:	No. of unpaid previous sessions
Referrer:	Referrer tel:
Reason for referral:	

Details of any relevant pre-existing conditions or treatment prior to the motor vehicle accident (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 working prior to MVA ☐ N/A ☐
Not RTW but work ready ☐

Current work duties:

Normal duties ☐ Modified duties ☐ Reduced hours ☐

Comments:

Initial/current subjective assessment

Initial/current objective assessment

Provider's provisional diagnosis

Functional limitations *(Include test scores from relevant outcome measure/s)*

Treatment progress since initial treatment/previous plan
(Detail change in outcome measure results)

Future treatment goals *(include short term functional goals such as work, travel, and ADL. Include any potential barriers)*

Details of treatment proposed

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

Other:

Insurer use only

Provider name:	Funding approved: Y ☐ N* ☐ Partial* ☐
Qualifications:	Details/comments:
Practice name and address:	
Email address:	Insurer signature: Date:
Phone: Fax:	Name:
Signature: Date:	*Insurer will provide written explanation if plan is partially/not approved

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.