

Initial plan *Subsequent plan

Treatment plan no: _____



PROVIDER TREATMENT PLAN – PSYCHOLOGICAL

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:	

***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

Current work status

Full-time
 Part-time
 Not returned to work
 N/A
 Not RTW but work ready

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/yy)	Psychological tests	Test scores and summary analysis

***Current diagnosis** (reference to DSM IV)

If subsequent plan: has current diagnosis changed since previous plan? Y N

Axis	Diagnosis and code (include all)	Approximate date of onset (dd/mm/yy)	Relationship to MVA: 1. Causally related 2. Unrelated 3. Exacerbation of pre-existing condition 4. Late onset
Axis I Clinical disorder	• • • •		
Axis II Personality disorder/ intellectual impairment			
Axis III General medical conditions			
Axis IV Psychosocial and environmental problems			
Axis V Global assessment of functioning score			

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

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

