

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).

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

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:

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)

Initial/current subjective assessment

Initial/current objective assessment

Provider's provisional diagnosis

Details of treatment proposed

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

Other:

_____ Insurer use only _____

Provider name:	Funding approved: Y <input type="checkbox"/> N* <input type="checkbox"/> Partial* <input type="checkbox"/>
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.