Patient information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Claim number |  | Date of accident |  | Date of birth |
|   |  |  / /  |  |  / /  |

|  |
| --- |
| Patient’s name |
|   |

1. Clinical indication

Please provide the clinical indication for the use of an opioid(s). *(*Tick all that apply).

|  |  |
| --- | --- |
| [ ]  Acute pain [ ]  Chronic pain [ ]  Sub-acute pain [ ]  Malignant pain [ ]  Other: |   |

By using opioids to manage pain / reduce pain levels, what are the expected areas of benefit? *(Tick all that apply)*

|  |  |
| --- | --- |
| [ ]  Function [ ]  Sleep [ ]  Mobility [ ]  Social [ ]  Return to work [ ]  Other: |   |

Does the patient have any of the following clinical factors? (*Tick all that apply)*

[ ]  Age > 60 [ ]  Heart disease [ ]  Dementia/Alzheimer’s [ ]  Diabetes[ ]  Recent falls

[ ]  Epilepsy [ ]  Mental health conditions/prescription[ ]  History of substance misuse

[ ]  Sex hormone replacement [ ]  Renal / Liver disease [ ]  Respiratory conditions [ ]  Not applicable

|  |  |  |
| --- | --- | --- |
| [ ]  Other (provide details): |  |   |

To give context to medication use, indicate which medications the patient was taking prior to the transport accident.

[ ]  Opioids [ ]  Sedatives [ ]  Neuropathic pain medications [ ]  None of these medications [ ]  Unknown

1. Multi-disciplinary involvement

Is a specialist involved in the opioid management? [ ]  Yes [ ]  No

|  |  |
| --- | --- |
| **If yes**, which specialty? [ ]  Pain physician [ ]  Psychiatrist [ ]  Addiction specialist [ ]  Other: |   |

|  |  |  |
| --- | --- | --- |
|  Specialist’s name |  |   |

**If no**, would you consider referring the patient to one of the above specialists?

 [ ]  Yes [ ]  No *Specialist services can be funded by the TAC.*

If the patient has persistent pain, has the patient participated in a multi-disciplinary Pain Management Service, e.g. the TAC/WorkSafe Network Pain Management Programs?

 [ ]  Yes [ ]  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If yes:** Program name |  |   | Year attended |   |

1. Opioid tapering strategy

Is an opioid tapering plan in place? [ ]  Yes [ ]  No

|  |  |  |
| --- | --- | --- |
| **If yes:** Commencement date for plan |  / /  |  Tapering duration (months) [ ] 1 to 3 [ ] 3 to 6 [ ] 6 to 12 [ ] >12  |

 If no: Has the patient attempted an opioid tapering plan previously? [ ]  Yes [ ]  No [ ]  Unknown

If a tapering plan is not in place, provide clinical rationale and any conditions that complicate or prevent opioid tapering.

|  |
| --- |
|   |

1. Prescribing information

Is a Schedule 8 treatment permit in place for this client?

|  |  |  |
| --- | --- | --- |
| [ ]  Yes [ ]  No [ ]  Not applicable | Date of expiry: |  / /  |

Is the patient subject to restrictive dispensing (e.g. daily or weekly)?

 [ ]  Yes [ ]  No [ ]  Not applicable

Have you completed a 12-month peer review evaluation and endorsement of the patient’s opioid treatment plan?

[ ]  Yes [ ]  No [ ]  Not applicable

Are you an approved pharmacotherapy (e.g. methadone/suboxone) prescriber?

 [ ]  Yes [ ]  No

Does the patient have Opioid Use Disorder (addiction or dependence)?

[ ]  Yes [ ]  No *Refer to the NPS MedicineWise website at* [*www.nps.org.au*](https://www.nps.org.au/) *for further information.*

Does the patient require medication assisted treatment of an Opioid Use Disorder, e.g. methadone/suboxone treatment?

[ ]  Yes [ ]  No *The TAC can support referral to appropriate programs.*

1. TAC support

The TAC Clinical Panel consists of experienced health and medical professionals who can support you as you treat TAC clients. They can provide advice about the most effective treatment options and pathways and offer recommendations for managing complex clients.

Would you like a clinician from the Clinical Panel to contact you in regard to your patient’s treatment? [ ]  Yes [ ]  No

|  |  |  |
| --- | --- | --- |
| Insert practice stamp if available  |  | Signature |
|  |  |  |
|  |  |
| Or fill in provider name, address and phone number |  |  |  |  |
|  | HIC provider no. |  |   |
|   |  |  |  |  |
|  | Qualifications |  |   |
|  |  |  |  |
|  | Date |  |  / /  |  |

 Two signature options:

1. Insert an image (jpg/png) of your signature in the field above and submit by email.

 2. Print the form, sign by hand, scan and submit by email.

Please attach any further information that supports this plan.

## 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.

Please return this form via email to info@tac.vic.gov.au and include the TAC claim number in the subject line.

## Your patient’s 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 [www.tac.vic.gov.au](http://www.tac.vic.gov.au)