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**Instructions**

Use this plan review to report on the progress of a TAC client. State the outcomes if the intervention is complete (Section 4) or if you recommend further occupational therapy services (Section 5).

# Section 1

## TAC client details

|  |  |
| --- | --- |
| First name |  |

|  |  |
| --- | --- |
| Last name |  |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |  | Date of accident | / / |

|  |  |
| --- | --- |
| Date of birth | / / |

|  |  |
| --- | --- |
| Street name and number |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |  | Post code |  |

|  |  |
| --- | --- |
| Client phone number |  |

|  |  |
| --- | --- |
| Client email address |  |

|  |  |
| --- | --- |
| Key contact if not client |  |

|  |  |
| --- | --- |
| Key contact phone number |  |

|  |  |
| --- | --- |
| Relationship of key contact |  |

(e.g. parent, partner, guardian)

# Section 2

## Progress towards goals and current intervention update

### Outline of current situation

Note any changes to injuries or medical condition, social situation, and current capabilities.

|  |
| --- |
|  |

### Progress towards achievement of goals

|  |  |  |
| --- | --- | --- |
| Goal, including measurable outcome,  if applicable | Achieved or  not achieved | Comments (include barriers to goal achievement) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Section 3

## Report of intervention completion

Complete this section if recommending that intervention is complete. If recommending further intervention, skip to Section 5.

Briefly outline outcome measure results, including recommendation for any follow up required. Attach scores or summary for any outcome measures used.

|  |
| --- |
|  |

# Section 4

## Proposed/revised goals for OT intervention

Complete this section if recommending further intervention or services. These goals should support areas of function identified by the person and be realistically achievable within the duration of the service plan.

### Goal

Ensure the goals are specific, measurable, activity based, achievable, realistic and timely (SMART goals). It should be clear how outcomes will be measured. Refer to notes if more information is required.

### Proposed strategies

Note who will be involved, e.g. OT, family members, other support people.

|  |  |  |
| --- | --- | --- |
| Goal | Proposed strategies | OT hours requested |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Total hours | |  |

# Section 5

## Plan justification

How will the OT plan address key life areas identified by the person, and contribute to enhancing participation in occupational activities and roles with reference to the [TAC Clinical Framework](https://www.tac.vic.gov.au/providers/working-with-the-tac/clinical-framework)? Are there any anticipated changes in support needs resulting from the plan that will assist a transition to self-management? For example, will the plan lead to increased independence and reduced funded support hours?

|  |
| --- |
|  |

# Section 6

## Other relevant information

|  |
| --- |
|  |

### Section 7

## Other recommendations

|  |  |
| --- | --- |
| Are you recommending assistive technology for this person? |  |

**If yes**, please outline. Refer to the [TAC occupational therapy guidelines](https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/occupational-therapy-guidelines).

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Are you recommending other services or assessments for this person? |  |

**If yes**, please outline.

|  |
| --- |
|  |

# Section 8

## Summary of hours and duration for OT intervention

|  |  |  |  |
| --- | --- | --- | --- |
| Total hours of individual services |  | Total hours of OT travel time (if required) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Proposed commencement date | / / | Proposed review date | / / |

If intervention is requested beyond the end date of this plan, the OT will be requested to complete another [OT Plan Review](https://www.tac.vic.gov.au/providers/documents-and-forms) after the above intervention timeframe.

# SECTION 9

## PROVIDER DETAILS

|  |  |
| --- | --- |
| Provider name, address,  email and phone number  (Type details or insert image of  practice stamp.) |  |

|  |  |
| --- | --- |
| SWEP credentialing level |  |

|  |  |
| --- | --- |
| Days/hours available |  |

|  |  |
| --- | --- |
| Signature  Insert image (jpg/png) of signature.  (Or print, sign and scan the form.) |  |

Icon

Description automatically generated

|  |  |
| --- | --- |
| Date | / / |

**Icon

Description automatically generated**

**Submitting this form**

Email your completed form to your TAC claims manager or to [info@tac.vic.gov.au](mailto:info@tac.vic.gov.au) with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

**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)