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**Instructions**

Use this form to provide details on the discharge of a TAC client from rehabilitation at home services. Complete only if you have registered with the TAC to deliver these services.

# Section 1

## TAC client details

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| Date of birth |  / /  | Client phone number |   |

|  |  |
| --- | --- |
| Discharge RAH date |  / /  |

|  |  |
| --- | --- |
| Discharge reason |   |

|  |  |  |
| --- | --- | --- |
|  | If ‘other’, provide details |   |

Factors or complications affecting progress of rehabilitation. If readmission, please add readmission reason.

|  |
| --- |
|   |

|  |  |  |
| --- | --- | --- |
|  | If ‘other’, provide details |   |

**Injuries for rehabilitation/treatment**

|  |  |  |  |
| --- | --- | --- | --- |
| Injury type | Side of body | Location | Specific location (e.g. thumb, 1-2 vertebrae) |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

# Section 2

## GOALS AND OUTCOME MEASURES

**EQ-5D-5L scores**

|  |  |
| --- | --- |
| Category  | Score  |
| Mobility |   |
| Self-care |   |
| Usual activities |   |
| Pain/discomfort |   |
| Anxiety and depression |   |

### Rehabilitation goals

|  |  |  |
| --- | --- | --- |
| Rehabilitation goal | Initial state | Final outcomes |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

### Final outcomes

|  |  |  |  |
| --- | --- | --- | --- |
| Measurable goals(e.g. attend local shops by increasing walking distance) | Measurable tool(e.g. six-minute walk) | Current measurable score and date (e.g. 100 metres recorded on 1 July 2023) | Discipline addressing each goal |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

### SECTION 3

## DETAILS FOR DISCHARGE

Assessed service and treatment needs at time of discharge from Rehabilitation at Home services and plan for transition of care, including equipment purchased

|  |
| --- |
|   |

Client’s level of function in activities of daily living (ADLs), including personal, domestic and community

|  |
| --- |
|   |

# SECTION 4

## PROVIDER DETAILS

|  |  |
| --- | --- |
| Clinician name, clinic name, billing number, address, email and phone number(Type details or insert image of practice stamp) |  |

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

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



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

****

**Submitting this form**

Email your completed form to either:

1. your TAC claims manager, or
2. info@tac.vic.gov.au with [sectors@tac.vic.gov.au](sectors%40tac.vic.gov.au) cc-ed

Include the client’s TAC claim number in the subject line. Please 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)