For ongoing treatment to be approved, it must be clinically justified by satisfying the five principles of the [Clinical Framework for the Delivery of Health Services](https://www.tac.vic.gov.au/providers/working-with-tac-clients/clinical-resources/clinical-framework).

## Client details

*(The client has a current claim with the TAC and is seeking psychological treatment for their transport accident injuries.)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Claim number |  | Date of accident |  | Date of birth |
| Click or tap here to enter text. |  | DD / MM / YYYY |  | DD / MM / YYYY |
| Client first name |  | Client last name |
| Click or tap here to enter text. |  | Click or tap here to enter text. |

## Referral

Who was the medical practitioner that referred this client to you?

|  |  |  |
| --- | --- | --- |
| Referrer’s name |  | Date of referral |
| Click or tap here to enter text. |  | DD / MM / YYYY |

|  |  |  |
| --- | --- | --- |
| Reason for referral |  |  |
| Click or tap here to enter text. |

## Current presenting problems

In order of priority, from most important to least important, list the problems that are currently preventing this client returning to valued roles in their family, social and productive work or related activities. For each problem give the key indicators, sign and symptoms associated with the problem.

|  |  |  |
| --- | --- | --- |
| Presenting problems  |  | Indicators, signs, symptoms |
| 1. |  Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. | Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| 3. | Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. | Click or tap here to enter text. |  | Click or tap here to enter text. |

|  |  |  |  |
| --- | --- | --- | --- |
| 5. | Click or tap here to enter text. |  | Click or tap here to enter text. |

## Head injury

|  |  |
| --- | --- |
| Did the person suffer a head injury | Choose Yes or No. |

## Current neurological status

On the basis of your assessment, if repeated since the last plan, report information on current status and effects on brain injury on function in the following areas. Please indicate if those problems are directly related to the transport accident.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Axis |  | Description |  | Functional problem? |  | Related to transport accident? |
| 1. | Cognitive (*e.g. memory,* *executive dysfunction*)  |  | Click or tap here to enter text. |  | Yes or No. |  | Yes or No. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 2. | Behavioural (*e.g. verbal and Physical aggression*) |  | Click or tap here to enter text. |  | Yes or No. |  | Yes or No. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 3. | Emotional (*e.g. anxiety, mood Disorder*) |  | Click or tap here to enter text. |  | Yes or No. |  | Yes or No. |

## Pre accident status

List the person’s pre accident status, including highest level of education achieved, employment at the time of the transport accident, other significant previous employment, social status and living arrangements. List pre accident issues including medical conditions.

|  |  |
| --- | --- |
|  | Pre accident status |
| 1. Highest level of education | Click or tap here to enter text. |

|  |  |
| --- | --- |
| 2. Employment at the time of transport accident | Click or tap here to enter text. |

|  |  |
| --- | --- |
| 3. Other significant previous employment | Click or tap here to enter text. |

|  |  |
| --- | --- |
| 4. Social situation and living arrangements | Click or tap here to enter text. |

|  |  |
| --- | --- |
| 5. Pre-existing issues  | Click or tap here to enter text. |

 *(Medical, Cognitive, Behavioural, Emotional, Social)*

## Identify risk factors for recovery

List priority risk factors likely to be barriers to a return to valued social and occupational roles.
*Risk factors may be physical, mental, social, cultural, occupational, legal*

|  |
| --- |
| Click or tap here to enter text. |

## Progress review

(*To be completed if the client has had 3 or more sessions to date*).

|  |  |
| --- | --- |
| Date of first session with yourself: | DD / MM / YYYY |

|  |  |
| --- | --- |
| Number of sessions completed to date: | Click to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Goals to date |  | Progress that has been achieved *(Functional gains)* |  | Outcome measure scores *(Please provide the name of measure and score. See* [*tac.vic.gov.au/outcomes*](https://www.tac.vic.gov.au/outcomes)*.)* |
| 1. | Click to enter text. |  | Click or tap here to enter text. |  | Click to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2.  | Click to enter text. |  | Click or tap here to enter text. |  | Click to enter text. |

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| --- | --- | --- | --- | --- | --- |
| 3.  | Click to enter text. |  | Click or tap here to enter text. |  | Click to enter text. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 4. | Click to enter text. |  | Click or tap here to enter text. |  | Click to enter text. |

## Client empowerment to manage their condition

*(Refer to Principle 3 of the Clinical Framework)*

Please comment on the client’s use of self-management strategies derived from treatment sessions.

|  |
| --- |
| Click or tap here to enter text. |

## Agreed future treatment plan

*(includes individual and group treatment)*

What practical goals have been agreed with the client? How will these goals be achieved, by what date, and using what
progress measures?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Practical goals *(Refer to Principle 4 of the Clinical Framework.)* |  | Interventions/strategies*(Refer to Principle 5 of the Clinical Framework)* |  | Expected functional gains/outcomes*(Refer to Principle 1 of the Clinical Framework)* |  | Outcome measures *(e.g. DASS, PCL, PSEQ. See* [*tac.vic.gov.au/outcomes*](https://www.tac.vic.gov.au/outcomes)*. Refer to Principle 1 of the Clinical Framework.)* |  | Estimated date of achievement or review |
| 1. | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | DD / MM / YYYY |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2. | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | DD / MM / YYYY |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3. | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | DD / MM / YYYY |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 4. | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | Click to enter text. |  | DD / MM / YYYY |

## Group treatment request

If the treatment plan includes group treatment for this client, please complete this section.
*(The goals of group treatment should be outlined with the agreed future treatment plan above).*

Please provide an outline of the group program. (*This may be an attachment if preferred*.)

|  |
| --- |
| Click or tap here to enter text. |

## Treatment requested for approval

|  |  |
| --- | --- |
| Duration of this plan: | Click to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Total hours of individual mental health treatment: |  | Commencement date of requested services |  | Completion date of requested services |
| Click to enter text. |  | DD / MM / YYYY |  | DD / MM / YYYY |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Total hours of group mental health treatment: |  | Commencement date of requested services |  | Completion date of requested services |
| Click to enter text. |  | DD / MM / YYYY |  | DD / MM / YYYY |

## Client’s natural supports

Please describe intervention to engage and strengthen client’s natural supports *(e.g. family and community relationships)*

|  |
| --- |
| Click or tap here to enter text. |

## Expected transition to self-management

*In accordance with Principle 3 of the Clinical Framework, treatment must focus on empowering the client to manage their injury.*

Please outline the plan for reduction in treatment frequency and transition to self-management

|  |
| --- |
| Click or tap here to enter text. |

|  |  |
| --- | --- |
| Date of expected discharge of client to self-management:  | DD / MM / YYYY |

## Multidisciplinary coordination and medications

*(Refer to Principle 2 of the Clinical Framework)*

|  |  |
| --- | --- |
| Have you liaised with others in relation to multidisciplinary coordination and medications? | Choose Yes or No. |

List other providers of treatment to this person, including professional and other carers and their interventions including psychotropic medication prescribed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Other provider/treatments*Names* |  | Current interventions/medications*Eg, Physiotherapy, drug name* |  | Date of your last contact with provider |
| 1. | Click to enter text. |  | Click or tap here to enter text. |  | DD / MM / YYYY |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2.  | Click to enter text. |  | Click or tap here to enter text. |  | DD / MM / YYYY |

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| --- | --- | --- | --- | --- | --- |
| 3.  | Click to enter text. |  | Click or tap here to enter text. |  | DD / MM / YYYY |

## Vocational needs

What are your client’s vocational goals? How are you supporting your client to achieve these goals?

|  |
| --- |
| Click or tap here to enter text. |

## Other comments and issues

Please note any other issues and needs for this person. This may include occupational, physical or social/family needs beyond those already expressed within this document.

|  |
| --- |
| Click or tap here to enter text. |

## Acknowledgement

This plan should be agreed to by the Neuropsychologist and the client to whom they are providing treatment.

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 select Yes. |  I agree |

## Provider details

|  |  |  |
| --- | --- | --- |
| Provider name, address and phone number Use practice stamp where possible |  | Two signature options:1. Insert an image (jpg/png) of your signature in the field below and submit by email.
2. Print the form, sign by hand, scan and submit by email
 |
|  |  | Qualifications |
|  | Click or tap here to enter text. |
|  | Registration number |
|  | Click or tap here to enter text. |
|  | Days/hours available |  | Date |
|  | Click or tap here to enter text. |  | DD / MM / YYYY |
|  | Signature |  |  |
|  |  |

## Your privacy

The TAC will retain the information provided and may use or disclose it to make further enquiries 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)