Treatment plan no:



PROVIDER TREATMENT PLAN – PHYSICAL

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| --- | --- |
| 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: | |
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Details of any relevant pre-existing conditions or treatment prior to the motor vehicle accident (MVA).

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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 

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| Comments: |
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Initial/current subjective assessment

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Initial/current objective assessment

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Provider’s provisional diagnosis

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

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Treatment progress since initial treatment/previous plan

*(Detail change in outcome measure results)*

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Future treatment goals *(include short term functional goals such as work, travel, and ADL. Include any potential barriers)*

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Details of treatment proposed

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| Proposed treatment: sessions, over weeks at $ per session |

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| Other: |
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Insurer use only

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|  | |  |  |
| Provider name: | Funding approved: Y  N\*  Partial\*  | | |
| 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](http://www.maic.qld.gov.au/) for a guide to completing treatment plans.

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Motor Accident Insurance Commission | [www.maic.qld.gov.au](http://www.maic.qld.gov.au/)