

## PROVIDER TREATMENT PLAN – PHYSICAL

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:	

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


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


**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

**Comments:**


**Treatment progress since initial treatment/previous plan**

*(Detail change in outcome measure results)*


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


**Initial/current subjective assessment**


**Details of treatment proposed**


**Initial/current objective assessment**


**Provider's provisional diagnosis**


**Proposed treatment:** \_\_\_\_\_ sessions, over \_\_\_\_\_ weeks  
 at \$ \_\_\_\_\_ per session

**Other:**


\_\_\_\_\_ Insurer use only \_\_\_\_\_

Provider name:	Funding approved: Y <input type="checkbox"/> N* <input type="checkbox"/> Partial* <input type="checkbox"/>
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.