Initial plan ☐ *Subsequent plan ☐ Treatment plan no: _____

PROVIDER TREATMENT PLAN – PSYCHOLOGICAL

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:	

***Relevant mental health history** *(details of any relevant mental health problems or treatment, including medication, prior to MVA)*

Pre-MVA work status
- Full-time ☐
- Part-time ☐
- Not working prior to MVA ☐

Current work status
- Full-time ☐
- Part-time ☐
- Not returned to work ☐
- N/A ☐
- Not RTW but work ready ☐

Current work duties
- Normal duties ☐
- Modified duties ☐
- Reduced hours ☐

Comments:

Current clinical findings *(including symptoms, frequency of occurrence, effect on function)*

***Test results/outcome measure results** *(for baseline and comparative purposes)*

Date (dd/mm/yy)	**Psychological tests**	**Test scores and summary analysis**

***Current diagnosis** *(reference to DSM IV)*

If subsequent plan: has current diagnosis changed since previous plan? Y ☐ N ☐

Axis	**Diagnosis and code** (include all)	**Approximate date of onset** (dd/mm/yy)	Relationship to MVA: 1. Causally related 2. Unrelated 3. Exacerbation of pre-existing condition 4. Late onset
Axis I Clinical disorder	•		
Axis II Personality disorder/ intellectual impairment			
Axis III General medical conditions			
Axis IV Psychosocial and environmental problems			
Axis V Global assessment of functioning score			

Additional comments regarding diagnosis *(e.g. is diagnosis provisional or is there a differential diagnosis?)*

***** *If completing a subsequent plan, there is no need to repeat information written in previous plan.*

Risk factors and appropriate treatment strategies relevant to the claim

(Note risk factors that may pose barriers to return to social and occupational roles e.g. compliance with treatment, severity of problem, previous treatment failure, severity of pre-morbid condition)

Treatment progress

Target problem (please describe in order of priority – most significant first)	**Treatment goals**	**Treatment method**	**Progress to goal attainment**

Details of treatment proposed: *(Treatment goals should include specific functional outcomes, be measurable and agreed to by the claimant)*

Target problem (please describe in order of priority – most significant first)	**Treatment goals** (incl. functional goals)	**Treatment method**	**Measures to be used**	**Review date** (dd/mm/yy)

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

Prognosis:

Has there been liaison with the claimant's treating medical or allied health providers? Y ☐ N ☐

Additional comments:

Insurer use only

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 for a guide to completing treatment plans.