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-the-tac/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 |
|  |  | / / | | |  | / / |
| Client first name | | |  | Client last name | | |
|  | | |  |  | | |

## Referral

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

|  |  |  |
| --- | --- | --- |
| Referrer’s name |  | Date of referral |
|  |  | / / |

|  |  |  |
| --- | --- | --- |
| Reason for referral |  |  |
|  | | |

## 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. |  |  |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 3. |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. |  |  |  |

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| --- | --- | --- | --- |
| 5. |  |  |  |

## Current and past diagnoses *(in accordance with DSM 5)*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Diagnoses | |  | Date of diagnosis |  | Are diagnostic criteria currently met? |  | Related to  transport accident? |
| 1. |  |  | / / |  |  |  |  |

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| 2. |  |  | / / |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 3. |  |  | / / |  |  |  |  |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| 4. |  |  | / / |  |  |  |  |

|  |  |
| --- | --- |
| Did you treat this client prior to the transport accident? |  |

## 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 |  |

|  |  |
| --- | --- |
| 2. Employment at the time of transport accident |  |

|  |  |
| --- | --- |
| 3. Other significant previous employment |  |

|  |  |
| --- | --- |
| 4. Social situation and living arrangements |  |

|  |  |
| --- | --- |
| 5. Pre-existing issues |  |

*(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*

|  |
| --- |
|  |

## Progress review

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

|  |  |
| --- | --- |
| Date of first session with yourself: | / / |

|  |  |
| --- | --- |
| Number of sessions completed to date: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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. |  |  |  |  |  |

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| 2. |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| 3. |  |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| 4. |  |  |  |  |  |

## 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.

|  |
| --- |
|  |

## 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. |  |  |  |  |  |  |  |  | / / |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 2. |  |  |  |  |  |  |  |  | / / |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 3. |  |  |  |  |  |  |  |  | / / |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 4. |  |  |  |  |  |  |  |  | / / |

## 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.)*

|  |
| --- |
|  |

## Treatment requested for approval

|  |  |
| --- | --- |
| Duration of this plan: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Total hours of individual mental health treatment: |  | Commencement date of requested services |  | Completion date of requested services |
|  |  | / / |  | / / |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Total hours of group mental health treatment: |  | Commencement date of requested services |  | Completion date of requested services |
|  |  | / / |  | / / |

## Client’s natural supports

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

|  |
| --- |
|  |

## 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

|  |
| --- |
|  |

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

## Multidisciplinary coordination and medications

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

|  |  |
| --- | --- |
| Have you liaised with others in relation to multidisciplinary coordination and medications? |  |

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. |  |  |  |  | / / |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2. |  |  |  |  | / / |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 3. |  |  |  |  | / / |

## Vocational needs

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

|  |
| --- |
|  |

## 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.

|  |
| --- |
|  |

## Acknowledgement

This plan should be agreed to by the psychologist 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.

|  |  |
| --- | --- |
|  | 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 | | |
|  |  | | |
|  | Registration number | | |
|  |  | | |
|  | Days/hours available |  | Date |
|  |  |  | / / |
|  | 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)