**National Injury Insurance Agency, Queensland**

Allied health treatment plan and report

Using this National Injury Insurance Agency, Queensland (NIISQ Agency) Allied health treatment plan and report:

* This treatment plan and report may be used for all allied health therapy interventions.
* This treatment plan and report can be completed following an initial assessment or following an approved block of treatment.
* A separate assessment or progress report is not required unless requested by the NIISQ Agency.
* Please submit this form with sufficient time for the NIISQ Agency to review the request.
Suggested timeframe: four weeks prior to the anticipated start date of the new treatment plan.
* Treatment recommended should be consistent with NIISQ’s [Treatment, care and support guidelines](https://niis.qld.gov.au/tcs-guidelines/).
* Please email all completed forms to requests@niis.qld.gov.au.

It is expected that while delivering NIISQ-funded services, providers adopt the [Clinical framework for the delivery of health services](https://www.tac.vic.gov.au/__data/assets/pdf_file/0010/27595/clinical-framework-single.pdf), within the standards and boundaries of their professional expertise.

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| This is allied health treatment plan number |  | Initial plan [ ]  Subsequent plan [ ]  Closure report [ ]  |
| Total number of consultations provided to date |  | Time since injury  | Months: Years:  |
| Date of injury | Click or tap to enter a date. | Date of initial consultation | Click or tap to enter a date. |

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| Provider details |
| Name |  | Company |  |
| Email |  | Phone |  |
| Qualifications and AHPRA registration number (if applicable) |  |

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| Participant information |
| Participant name |  | NIISQ case number |  |
| NIISQ-eligible injury | SCI [ ] Level: AIS:  | TBI [ ]  | Burns [ ]  | Blindness [ ]  | Amputation(s) [ ]  | Brachial [ ] Plexus |
| Injury/injuries being treated |  |
| NIISQ MyPlan start date | Click or tap to enter a date. | NIISQ MyPlan end date | Click or tap to enter a date. |
| NIISQ MyPlan goal/s relevant to this treatment plan and report |  |

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| Assessment outcomesOnly complete if this is an initial treatment plan |
| Subjective measures |  |
| Objective measures |  |

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| Outcomes of previous treatmentOnly complete if this is a subsequent treatment plan |
| Previous SMART treatment goals | Goal attainment |
|  | Yes [ ]  No [ ]  Partial [ ]  |
|  | Yes [ ]  No [ ]  Partial [ ]  |
|  | Yes [ ]  No [ ]  Partial [ ]  |
|  | Yes [ ]  No [ ]  Partial [ ]  |
| Description of treatment provided |  |
| Subjective outcome measures |  |
| Objective measures (include functional measures where appropriate) |  |
| How the treatment provided has supported the participant to work towards their NIISQ MyPlan goals |  |
| Other comments (e.g. issues affecting treatment) |  |

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| Treatment planDo not complete if this is a closure report |
| SMART treatment goals for this treatment plan period | Anticipated timeframe for achievement (must fall within the treatment plan period) |
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| Treatment modalities |  |
| How the proposed treatment will assist the participant to work towards achieving their NIISQ MyPlan goals |  |
| Objective outcome measures that will be used to measure goal achievement (include functional measures where appropriate) |  |
| Strategies to promote capacity-building and self-management, or advice regarding why this is not possible |  |
| Anticipated barriers and strategies to manage these |  |

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| Treatment plan datesThese dates must fall within the participant’s MyPlan dates |
| Start | Click or tap to enter a date. | Finish | Click or tap to enter a date. |

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| QuoteDo not complete if this is a closure report |
| Service descriptionEnsure all service types are listed separately (e.g. therapy (*indicate discipline*), assessment, provider travel) | Units (e.g. hours) | Quantity | Cost per unit/session – GST excluded | Total cost |
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|  |  |  |  |  |
|  |  |  |  |  |
| TOTAL |  |

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| Allied health provider declaration |
| This treatment plan/report has been developed in consultation with the participant. *If treatment is recommended*: The participant (including formal/informal decision-maker) agrees with this treatment plan/report and commits to participating.*If no further treatment is recommended:* The participant (including formal/informal decision-maker) is aware of and understands this. | *(Provider signature)* |
| Date | Click or tap to enter a date. |

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