**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](mailto: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 outcomes  Only complete if this is an initial treatment plan | |
| Subjective measures |  |
| Objective measures |  |

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| Outcomes of previous treatment  Only 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 plan  Do 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 dates  These 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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| Quote  Do not complete if this is a closure report | | | | |
| Service description  Ensure 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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| TOTAL | | | |  |

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

NIISQExForm15v2