**Logo

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**Allied health treatment plan and report**

**Initial Treatment Plan**   **Subsequent Treatment Plan**

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| **Completing the treatment plan and working within the National Injury Insurance Scheme, Queensland (NIISQ)**   * This treatment plan may be used for all allied health therapy intervention and can be completed following an initial assessment or after an approved block of treatment. * A separate assessment or progress report is not required unless requested by the NIISQ Agency.   It is expected that providers working within the NIISQ 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. |

1. **Person’s details and referral information**

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | Participant case number |  |
| Participant name |  |  |  |
| Date of injury |  | Age |  |
| Date of initial assessment |  | Total number of sessions since initial assessment |  |
| Purpose of referral / reason for intervention  *Please attach any referral documentation* |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Injury you are treating *(please select)* | | | Other (specify) |
| Traumatic brain injury |  |  |  |
|  |  |  |
| Spinal cord injury |  |  |
|  |  |  |
| Level |  | |
|  |  |  |
| ASIA score |  | |

1. **Participant’s NIISQ support plan goals**

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| The participant’s goal/s in their NIISQ support plan relevant to this service request. |
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1. **Impact of previous treatment (if this is not an initial assessment treatment plan)**

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| --- | --- |
| **Treatment provided to date**  *(please detail treatment in previous funding period)* | |
|  | |
| Previous treatment goal/s (from previous treatment plan) | Achieved |
| 1. | Yes  No  Partially |
| 2. | Yes  No  Partially |
| 3. | Yes  No  Partially |
| **Outcomes of treatment (including outcome measures)**  *(please detail outcome measures related to the functional goals of treatment that demonstrate the effectiveness of previous intervention. Include any barriers to goal achievement / progress)* | |
|  | |

1. **Participant’s current status**

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| --- |
| **Subjective assessment**  *Participant/carer self-reporting on current presentation, home/ community/ vocational participation including workdays/hours, goals and progress towards goals* |
|  |
| **Objective assessment (if not covered under Section 3. Impact of previous treatment)**  *Please use validated outcome measures that will assist in understanding how the proposed intervention has / will assist the participant reach their functional goal/s.* |
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| **Other relevant information**  *Include any relevant information that will assist in understanding the participant’s current situation, biopsychosocial factors, their treatment history, trials of other intervention, other treatment providers involved.* |
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| **Complete sections 5 and 6 if treatment is recommended** |

1. **Recommendations / service request**

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| --- | --- |
| **SMART treatment goals**  *(The treatment goals should focus on optimising function, participation and return to work and should directly relate to and help the participant achieve their Support Plan goal/s (Section 2))* | **Estimated date of achievement**  *(Date to be within the proposed funding period)* |
| 1. |  |
| 2. |  |
| 3. |  |
| **Treatment strategies**  *(please detail the evidence-based treatment necessary to achieve the treatment goal/s)* | |
|  | |
| **Detail how the effectiveness of treatment will be measured**  *(please detail the relevant outcome measures to be used)* | |
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| **Self-management strategies** | |
|  | |
| **Other recommendations / comments / additional information** | |
|  | |

1. **Proposed treatment plan to provide the above intervention**

*Intervention should be based on the best available evidence, agreed to by the participant, facilitate self-management and be cost effective.*

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| --- | --- | --- | --- | --- |
| **Type of treatment session** *(eg standard physiotherapy, OT, speech pathology, exercise physiology session, home visit, group session)* | **Total number of sessions** | **Start date**  *(approx.)* | **Funding period**  *Eg over 3 months* | **Cost per session** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Other recommendations** *(including time period and cost)* | | | | |
|  | | | | |

1. **Service provider details and declaration**

|  |  |  |  |
| --- | --- | --- | --- |
| Name |  | | |
| Qualifications and registration status |  |  |  |
| Employer |  | Contact number |  |
| Address |  | | |
| Email |  | | |

This treatment plan has been developed in consultation with the participant. The participant (and family member or nominated person if appropriate agrees with this treatment plan and is committed to participating.

|  |  |  |  |
| --- | --- | --- | --- |
| Provider signature |  | Date |  |

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| --- |
| Please contact the Support Planner with any queries and / or to discuss the participant’s progress. If further treatment is required following this treatment plan, please contact the Support Planner to complete a subsequent treatment plan.  **Please send completed treatment plan to requests@niis.qld.gov.au.** |