SIRA

Allied health treatment request

To be used by allied health practitioners working with NSW workers compensation (WC) and motor accidents (CTP) injury claims.

How do I complete this form?

1. Fill out form with the injured person. All sections should be completed
2. Sign form
3. Submit form to the injured person's insurer

Once submitted, insurers have:

- 21 days to respond to requests for treatment in the WC scheme (except for services specified in Table 4.1 of the *Workers compensation guidelines:* sira.nsw.gov.au/workers-compensation-claims-guide/legislation-and-regulatory-instruments/guidelines/workers-compensation-guidelines
- 10 days in the CTP scheme.

Where do I go for help?

Read the Allied health treatment request explanatory notes at: sira.nsw.gov.au/ahtr

Request number

Date of request (DD/MM/YYYY)

This is the number of request forms submitted

Date services first commenced (DD/MM/YYYY)

Total number of consultations to date

Your allied health discipline Please select

Other

Referred by

Phone number

Section 1: Injured person details

Name

Date of birth (DD/MM/YYYY)

Pre-injury occupation

Pre-injury work hours/week (average)

Claim number

Date of injury/accident (DD/MM/YYYY)

Section 2: Your clinical assessment

Compensable injury/illness

Current clinical signs and symptoms

Risk screening

Have you applied a risk screening tool in your assessment? ☐ Yes ☐ No

e.g., OMPSQ-SF, Keele STarT Back, Whip-Predict, K10 etc

Name of risk screening tool

Date administered (DD/MM/YYYY)

Score/comment

Details of any pre-existing conditions directly relevant to the compensable injury

Capacity

Do you have a copy of the position description/work duties (WC and where relevant CTP)

☐ Yes ☐ No If no, insurer to provide.

	Pre-injury capacity Describe what the person did before the injury(s) related to this claim	Current capacity Describe what the person can do now
Work occupation, tasks, days/hours worked		
Usual activities activities of daily living, driving, transport, leisure		

Standardised Outcome Measures (SOM) – At least one measure to be reported

Measure	Initial score Date and score of the first SOM completed		Previous score Date and score of the SOM completed for submission of the previous AHTR		Current score Date and score of the latest SOM completed	
	Date	Score	Date	Score	Date	Score
e.g. Neck Disability Index	1/02/23	21/50	N/A	N/A	26/03/23	14/50
e.g. DASS	1/02/23	Depression =24 Anxiety=19 Stress=33	22/03/23	Depression=19 Anxiety=15 Stress=28	21/07/23	Depression=15 Anxiety=11 Stress=22
1.						
2.						
3.						

Interpretation of score(s)

Section 3: Barriers to recovery and strategies to address

Barriers to recovery identified through your screening and assessment

Strategies to address barriers to recovery (may include actions to be taken by you/injured person, strategies agreed with others in treating team, referral to other services, etc):

Would you like any of the following assistance?

Direct contact from the insurer ☐ Yes

Case conference ☐ Yes, who with

Collaborative case review with an independent consultant? ☐ Yes

Section 4: Treatment plan

Has the injured person achieved the goals from the last treatment plan?

☐ Yes ☐ No ☐ Partially ☐ N/A

Injured person goals
(Goals should be Specific, Measurable, Achievable, Realistic, Timed (SMART))
e.g. To return to my usual job as a retail assistant by 4 August; To drive for an hour to my parent's home by 6 July; To return to training my kid's soccer team by 3 October.

	To	by
1. Work goal or activity goal if not working at time of injury		
2. Activity or participation goal		

Injured person's self-management (what techniques/strategies/exercises are they completing between sessions?)

Your intervention

Outline the rationale for the services you are requesting

How many additional sessions do you anticipate before discharge?

Anticipated discharge date (DD/MM/YYYY)

If this date has changed since the last plan, please explain why

Did you collaboratively develop this treatment plan with the injured person? ☐ Yes ☐ No

If No, please explain why

Section 5: Service requested

Service type include consultation type, other services e.g., aids/equipment	Number of sessions or hours if case conferencing	Frequency/ timeframe e.g., 1 consultation/week	Service code where applicable	Cost per session/item	Total cost
					$ 0.00
					$ 0.00
					$ 0.00
					$ 0.00
					$ 0.00
				Overall total	$ 0.00

Section 6: Your details

Treating practitioner name

Practice email

AHPRA number

Best time/day to contact

Practice name

SIRA approval number (WC only)

Suburb

State

Postcode

Treating practitioner email

Phone number

Fax

Signature

Section 7: Insurer decision

☐ Approved ☐ Approval of some services only ☐ Declined ☐ More information required

An explanation must be provided below if the insurer's decision is 'Approval of some services only', 'Declined' or 'More information required'.

Insurers note: You must provide additional documentation to support the decision to decline any services. This must be in line with legislative obligations.

Explanation

Contact name

Signature

Phone number

Date (DD/MM/YYYY)

Email

State Insurance Regulatory Authority

NSW GOVERNMENT