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| **Client’s Details** | | | |
| Client name: | Click here to enter text. | | |
| Claim number: | Click here to enter text. | | |
| Occupation & employer: | Click here to enter text. | | |
| Current work status: | Select One | | |
| **Referrer Details** | | | |
| Referral date:  Click here to enter a date. | | Copy of referral letter attached?  Yes or No | |
| Referred by:  Click here to enter text. | | Is this referral indicated in current statement of fitness for work/medical certificate?  Yes or No | |
| Referrer contact details: Click here to enter text. | | | |
| Reason for referral: Click here to enter text. | | | |
| **Treatment Provider Details** | | | |
| Select a Provider Type | | | |
| Click here to enter text. | | | |
| Date: Click here to enter a date. | | | Business name: Click here to enter text. |
| Provider name: Click here to enter text. | | | Address: Click here to enter text. |
| Provider signature: | | | Telephone / Fax: Click here to enter text. |
| Provider number: Click here to enter text. | | | Email address: Click here to enter text. |
| Practice stamp | | | |

Gallagher Bassett promotes the biopsychosocial approach set out in the Clinical Framework for the Delivery of Health Services. In completing the proceeding sections of this form, please ensure that these factors are considered as part of the assessment and treatment interventions. Early intervention of risk helps address issues that can impact recovery.

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| **Proposed Treatment Plan** | |
| Identify injury/s this PMP relates to: Click here to enter text. | Has GB accepted liability for the injury/s? Yes or No |
| This is PMP No. Click here to enter text. | Date of initial consultation: Click here to enter a date. |
| Commencement date for this PMP: Click here to enter a date. | Total consultations approved to date: Click here to enter text. |
| End date for this PMP: Click here to enter a date. | Anticipated discharge date: Click here to enter a date. |
| Number of consultations requested in this PMP: Click here to enter text. | Anticipated discharge date and total consultations required: Click here to enter a date.  Click here to enter text. |
| **Assessed status** | |
| Presenting signs and symptoms / clinical observations | |
| Click here to enter text. | |
| Treatment Provider’s Clinical Diagnosis/Diagnoses | |
| Click here to enter text. | |
| Identify and justify the relationship between the compensable injury and diagnosis | |
| Click here to enter text. | |

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| **Outcome Measures** | | | |
| How you intend to determine baseline levels and then measure and demonstrate the effectiveness of the treatment carried out. Please identify measures to assess and monitor the client’s progress throughout the treatment period. | | | |
| **Outcome Measure** | **Measure at Initial Assessment** | **Current Measure (at commencement of this plan)** | **Anticipated outcome at the end of this plan** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| **Agreed treatment plan and measures** | | | |
| What practical goals have been agreed with the client that focus on optimising function, participation and return to work? What evidence base validates the proposed treatment? How is the treatment aiming to empower your client to manage their injury independently? Please outline, in addition to treatment provided, what self-management strategies are being provided to empower your client. | | | |
| **Goals** | | **Interventions/strategies to achieve goal** | |
| Click here to enter text. | | Click here to enter text. | |
| **Contributing / Psychosocial Factors** | | | |
| Please detail any contributing factors, psychosocial issues or other barriers present that may impact on treatment or recovery and any recommendations to overcome these. | | | |
| **Contributing or psychosocial factor** | | **Recommendation/s to overcome barrier** | |
| Click here to enter text. | | Click here to enter text. | |

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| **Other comments, issues, further investigations or referrals requested** | | | |
| Can we assist your management in any other way? (ie. Xrays, referral/s to specialist etc). If so, please detail below. Please note any other issues and needs for this client. This may include occupational, physical, social or family needs. GB may be able to consider funding additional reasonable services where they are directly related to the compensable injury. Please clearly indicate if you are requesting vocational assistance for this person. | | | |
| Click here to enter text. | | | |
| **Services Requested** | | | |
| Choose an item. | | | |
| **Type of service (eg. initial consult)** | **Cost of service** | | **Frequency of consultations (eg. 1/fortnight)** |
| Click here to enter text. | Click here to enter text. | | Click here to enter text. |
| **Agreement to proposed PMP by provider and client** | | | |
| This plan should be signed by the provider and the person for whom they are providing services. | | | |
| Name of Provider: Click here to enter text. | | Name of Client: Click here to enter text. | |
| Signature: | | Signature: | |
| Date: Click here to enter a date. | | Date: Click here to enter a date. | |

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| **Gallagher Bassett Use Only** | |
| Client name: Click here to enter text. | |
| Business name: Click here to enter text. | |
| Provider name: Click here to enter text. | |
| PMP Number: Click here to enter text. | |
| PMP Duration: From Click here to enter a date. To Click here to enter a date. | |
| PMP Decision: Choose an item. | |
| Comments: Click here to enter text. | |
| Name of Claims Officer: Click here to enter text. | |
| Contact Number: Click here to enter text. | |
| Signature: | Date: Click here to enter a date. |