Initial Plan ◉ Subsequent plan ○ Treatment Plan Number: _____

CTP INSURANCE REGULATOR

Allied Health Management Plan - PHYSICAL

This management plan will be considered by SA CTP Approved Insurers when deciding whether to fund a service. Interventions should be aimed at **functional recovery** with achievable and measurable goals, consistent with available **research evidence** and clinical guidelines, and encouraging the injured claimant's **self-management**. As a general rule and to be confident of payment, pre-approval should be obtained from the Approved Insurer for payment of services. Providers may charge for completion of the Management Plan in accordance with ReturntoWorkSA fee schedule. Find out more from the CTP Insurance Regulator's Injury Recovery & Early Intervention Framework, available at: www.ctp.sa.gov.au

Claimant details					
Full Name:		◉ **AAMI**	○ **Allianz**	○ **SGIC**	○ **QBE**
Claim Number:		**No. of sessions to date:**			
Date of accident:		**Date of initial consult:**			
Employment status:	◉ Yes ○ No	**If employed, occupation title:**			
Pre-injury hours/week:		**Current hours/week:**			
Referrer:		**Referrer telephone:**			
Reason for referral:					

Initial/Current Biopsychosocial Assessment	
Presenting injury/injuries: *(as a result of the accident)*	
Pre-existing conditions or treatment prior to the accident:	
Relevant psycho-social factors:	
Actions taken for the above psycho-social factors:	

Initial/Current Objective Assessment				
Outcome Measures* (recommend >2)	**Previous** (☐ tick if first form)		**Update**	
	Date	**Score**	**Date**	**Score**
1.				
2.				
3.				
Claimant's functional limitations: *(identified from the above measures)*				

Diagnosis and Treatment Plan			
Provider's provisional diagnosis:			
SMART Goals* *(Functional & Work Goals)*	Estimated date of achievement	Plan of how it will be achieved (e.g. treatment type & frequency)	
		Specific Treatment Type (e.g. hands-on, exercise, etc.)	**Frequency & Duration**
1.			sessions/week for weeks
2.			sessions/week for weeks
3.			sessions/week for weeks
Self-management strategies recommended: *(e.g. home exercise, ADL management, return to work, etc.)*			
Total No. of Proposed Treatments:	_____ **sessions, over** _____ **weeks. RTWSA Fee Schedule applies.**		
Others/Comments:			

*Refer to the Injury Recovery and Early Intervention Framework for more information, available at: http://www.ctp.sa.gov.au/.

Please proceed to the next page →

Allied Health Provider Details			
Provider Name:			
Practice Name & Address:			
Profession of Provider(s)			
Registration Number (if applicable):			
Contact Details:	Phone:	Fax:	Email:
The claimant has been involved in the development of this management plan			☐ Yes
A copy of this plan has been provided to the claimant			☐ Yes

I declare that I am a registered health practitioner and that the information provided here is true and correct to the best of my knowledge.
I agree that CTP Approved Insurers may contact me should any of the above information require clarification.

Signature: **Date:** / /

Please forward the completed Management Plan, copies of medical referrals/correspondence and outcome measures directly to the relevant Approved Insurer from below:

Insurer:	**AAMI**	**Allianz**	**QBE**	**SGIC**
Email:	**sactpclaims@aami.com.au**	**claimssactp@allianz.com.au**	**myctpclaim@qbe.com**	**piclaims@iag.com.au**

CTP APPROVED INSURER USE ONLY

Injury Recovery Interventions Funding Approval

Date:

The CTP Insurance Regulator's Injury Recovery and Early Intervention Framework requires Approved Insurers to respond to your funding request(s) in writing within 7 business days of receipt of the request. Visit www.ctp.sa.gov.au for more information.

The following is the written response to your requested service(s) as outlined in this management plan:

Funding approval:	☐ Yes ☐ Partial No. of Sessions Approved (if applicable): ☐ No
If service is partially approved or not approved, the reasons are as follows:	

Insurer Officer's Name:

Officer's Signature:

Insurer contact details: