



Australian Government

Comcare

PUTTING YOU *FIRST*

PHYSIOTHERAPY TREATMENT NOTIFICATION PLAN

PRIVACY

Comcare will retain the information and may use or disclose it to make further enquiries or assist in the ongoing management of the claim or any claim for common law damages. Comcare may also be required by law to disclose this information

Without this information, Comcare may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment.

Please refer to the notes for assistance in completing this form.

Lodgement of TNP

Fax 1300 196 971

Email clinical.panel@comcare.gov.au

Post GPO Box 9905, Canberra 2601

INJURED WORKER DETAILS

Name

Claim number

CURRENT WORK STATUS

Occupation/job title

Normal duties

Modified duties

Not working

Has the Injured Worker attended your practice prior to this work-related injury?¹ Yes No

if yes, please specify condition and treatment

Specific anatomical site of work-related injury and clinical diagnoses²

Current reported symptoms and physical assessment findings³

Provide details of relevant standardised outcome measures (SOM) used, date administered and initial assessment score(s)⁴

Date administered	SOM(s)	Baseline score

List current activity/functional limitations and related goals⁵

Current activity/functional limitations	Short term activity goals include ADL and work/travel goals	Estimated date of achievement
1.	1.	/ /
2.	2.	/ /
3.	3.	/ /
4.	4.	/ /

Proposed treatment plan from today's date⁶

Total no. of services over weeks from / / to / /

Proposed treatment methods including client self management strategies⁷

PROVIDER DETAILS

I have current registration with Australian Health Practitioner Regulation Agency

Yes No

Provider name, address and phone no.

Signature

Date / /

Days/hours available

COMCARE INJURED WORKER AUTHORISATION⁸

I (please print your name)

Hereby authorise you to supply Comcare with information requested on this form and to discuss the contents of this form, and any ongoing issues of my treatment, with officers or representatives of Comcare.

Signature of Injured Worker or guardian

Date / /

All questions must be answered for this plan to be considered. Please use block letters and attach any information that may be relevant.