**Community Integration Program Claim Review Summary Form:**

Spinal

Please complete this form for injured workers who may be eligible for transfer into the Community Integration Program.

Please provide a brief description of the reasons for referral to the CIP.

Which specialised medical and like support is required by the worker to assist them in their activities of daily living?

|  |
| --- |
|   |

Date sent to WorkSafe:

WorkSafe Victoria Agent:

Claims Manager Name:

Direct Contact Number:

Claim Status:

|  |
| --- |
| **Worker’s Details** |

WorkSafe Victoria Claim No:

Worker name:

Date of Birth:

Current Age:

Worker Address:

Worker Phone number:

Administrator/Guardian details (if relevant):

|  |  |  |
| --- | --- | --- |
| **Name** | **Phone** | **Relationship** |
|       |       |       |
|       |       |       |

Domestic status:

|  |  |  |
| --- | --- | --- |
| **Name** | **Age (if relevant)** | **Living with worker** |
| Partner:       |       | Yes [ ]  No[ ]  |
| Child :       |       | Yes [ ]  No[ ]  |
| Parent (s):       |       | Yes [ ]  No[ ]  |
| Siblings:       |       | Yes [ ]  No[ ]  |

|  |
| --- |
| **Injury Details** |

Date of Injury:

Summary of accident:

Generic Injury description: (e.g. C6 incomplete quad)

Quadriplegic [ ]  Paraplegic [ ]

Acute Hospital details:

Consultant’s name:

Rehabilitation Hospital details:

Consultant’s name

**Post injury surgery**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Surgery type / detail** | **Outcome** | **Name of Surgeon / Hospital** | **Current issues** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

|  |
| --- |
| **Current Status** |

* Residential status:
* Medical status:
* Conscious state / cognition:
* Communication:
* Physical/mobility:
* Psych / behaviour:
* Neuropsychology reports:
* Social:
* Education / Employment:
* Recreational involvement:
* Personal Activities of Daily Living (PADL)/Domestic Activities of Daily Living (DADL)/Communication Activities of Daily Living (CADL):

**Identified Risk Flags**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risks** | **No** | **Yes** | **If Yes, please provide specific details.**  |
| **Harm to Self** |  |  |       |
| **Harm to Others** |  |  |       |
| **Harm to Self and Others** |  |  |       |
| **Notable Behaviour** |  |  |       |

**Current Medications**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication Name** | **Prescribed by (if known)** | **Reason** | **Injury related or pre-existing** | **Dosage (If available)** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

**Current Medical / Paramedical / Rehabilitation Provider Summary**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name / Company** | **Discipline/Service/ Other**  | **Current approved hours / frequency** | **Treatment/ Intervention goals**  | **Contact details** | **Comment** | **Commencement of date of service** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Current Equipment Summary**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Equipment Type/ Modification** | **Details** | **Date of request** | **Date Received** | **Comment of progress** |
| **Wheelchair** |  |  |  |  |
| **Recreational equipment** |  |  |  |  |
| **Vehicle** |  |  |  |  |
| **Home modification** |  |  |  |  |
| **Other:** |  |  |  |  |

|  |
| --- |
| **Common Law / Dispute resolution / Impairment / Income** |

* Common Law:
* Dispute resolution:
* Impairment:

 **Termination/ Reduction in services:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service type** | **Date of termination/reduction** | **Reasons for termination/reduction** | **Disputation details****(if applicable)** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| WorkSafe Victoria/TAC Community Integration Initiative Spinal Functional Coding  |

*Please enter one tick per section (ASIA Code, Mobility Code and Quadriplegics only- Ventilated) to indicate the injured worker’s current status.*

|  |
| --- |
| ASIA Code – Spinal |

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | A | **Complete disruption of function and sensation** No motor or sensory function is preserved in the sacral segments S4-S5. | *Complete* |
| [ ]  | B | **Complete disruption of motor function, some sensation** Sensory but not motor function is preserved below theneurological level and includes the sacral segments S4-S5. | *Incomplete* |
| [ ]  | C | **Some weak motor function, and some sensation**Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3. | *Incomplete* |
| [ ]  | D | **Some strong motor function and sensation** Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a muscle grade of 3 or more. | *Incomplete* |
| [ ]  | E | **Near normal motor function and sensation**Motor and sensory function are normal. | *Incomplete* |

|  |
| --- |
| Mobility Code - Spinal |

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | A | Limited head and neck movement (C1-C3) | *Quads* |
| [ ]  | B | Head and neck control may shrug shoulders (C4) | *Quads* |
| [ ]  | C | Has shoulder control and can bend elbows with palms up (C5) | *Quads* |
| [ ]  | D | As above (C) plus can extend wrists and turn palms up & down (C6) | *Quads* |
| [ ]  | E | As above (C & D) plus limited to natural hand function (C7-C8) | *Quads* |
| [ ]  | F | Full UL control, limited upper trunk stability (T1-T4) | *Para* |
| [ ]  | G | As above (F) plus fair to good upper trunk stability (T5-T9) | *Para* |
| [ ]  | H | As above (G) plus good trunk control T10-L1) | *Para* |
| [ ]  | I | As above (H) plus partial or full control of lower extremities (L2-S5) | *Para* |

|  |
| --- |
| Quadriplegics Only - Ventilated |

|  |  |
| --- | --- |
| [ ]  | Yes |

|  |  |
| --- | --- |
| [ ]  | No |

|  |  |
| --- | --- |
| Indicator | Score |
| **Functional Independence Measure (FIM)**Is a basic indicator of patient disability used to track the changes in the functional ability of a patient during an episode of hospital rehabilitation care. |       |

**-------------------------------End of form-----------------------------**

Thank you for completing the above application and supplying all relevant documentation. This information is to be considered indicative only and is subject to WorkSafe Victoria confirmation and endorsement. All information will be reviewed in order to determine eligibility for transfer to the Community Integration Program.

**Submitting Application**

Please return all completed forms and supporting documentation to one of the following representatives:

**Liz Gibson**

liz\_gibson@worksafe.vic.gov.au

**Sacha English**

sacha\_english@worksafe.vic.gov.au

**Molly McIntosh**

molly\_mcintosh@worksafe.vic.gov.au

# Further Information

If you need advice or further information about the Community Integration Program or eligibility criteria, please contact the following representatives:

**Sacha English**

Agent Contract Coordinator

WorkSafe Victoria

**Phone (direct):** (03) 9940 4071

**Email:** sacha\_english@worksafe.vic.gov.au