This form is for use by Framework Occupational Therapists providing services to TAC and WorkSafe. The information in this form is for use by the organisation which has requested it and will not otherwise be exchanged with any other party, except in accordance with law. Please see section 14 of this form for further information.

**IMPORTANT**

* Please type or use block letters and **ensure that all sections are complete.** All incomplete forms will be returned, so please give reasons if you are unable to complete a section.
1. Client/Worker details

|  |  |  |
| --- | --- | --- |
| Client/Worker name |  | Type of claim |
|       |  | TAC [ ]   | WorkSafe [ ]  Agent:       |
| Client/Worker address |  | Claim number |  | Telephone number |
|       |  |       |  |       |
|       |  | Date of Birth  |  | Date of injury |
|       |  |       /       /       |  |       /       /       |
|       Postcode       |  | Employer |  | Employer telephone number |
|   |  |       |  |       |
| Current occupation:       |  | Date of assessment  |  | Date report submitted  |
| Pre-injury occupation:       |  |       /       /       |  |       /       /       |

Reason for referral

|  |
| --- |
|        |

1. Current services

|  |  |  |
| --- | --- | --- |
| **Services** | **Funding source** | **Current hours of funded services** |
| Attendant care |  |  |
|  Personal care | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
|  Therapy support | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
|  Community access | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
|  Inactive sleepovers | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
|  Active sleepovers | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
|  Daily support | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Allied health assistant | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Community based rec/leisure supports *(e.g. neighbourhood house)* | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Community group programs | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Childcare | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Home services | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Gardening | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Residential care | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| On-Call services Day [ ]  and/or Night [ ]  | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |
| Other *please specify* | [ ]  TAC [ ]  WorkSafe [ ]  Non-funded [ ] Other [ ]  N/A |       |

Comments about other funding

|  |
| --- |
|       |

1. Background information and transport accident/work-related injury details
2. Injury details

Provide injury details, any additional medical information, treatment, medical interventions to date and subsequent health conditions. *Provide the information source, e.g. treating medical practitioner, physiotherapist*

|  |
| --- |
|       |

1. Details of any pre-injury conditions and subsequent non-injury-related conditions

*Detail impact on current level of function and need for services*

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1. Comment on the client/worker’s ability to participate in this review and their level of satisfaction with the current funded program

|  |
| --- |
|       |

1. Post-injury level of function
2. Current level of function at (1) home, (2) work/school, (3) in the community and (4) with recreational/leisure activities

Comment on any relevant issues affecting the client/worker’s ability to participate, or potential barriers to reaching optimum levels

|  |
| --- |
|       |

1. Current (1) physical, (2) cognitive and (3) behavioural status

Comment on physical mobility, transfers, cognitive/psychological/emotional and communication/swallowing

|  |
| --- |
|       |

1. FIM/FAM assessment

Where specifically requested by the TAC/WorkSafe Agent to conduct a Functional Independent Measure/Functional Assessment Measure of the client/worker, the Assessor must attach the *Benefit and Support Services Assessment: FIM/FAM* form.

Has a FIM/FAM assessment been undertaken and is attached to this report? [ ]  Yes [ ]  No

1. Summary of activities

These tables are designed to identify the amount of support time required for either maintenance or rehabilitation-focused activities. Only complete each table if the client/worker requires assistance in the specified area of activity

1. Personal care activities

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Functional level** | **Type of assistance required** | **Support type** | **Is the client/worker’s status likely to change?** | **Current hours** | **Recommended hours** |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|  | Total |       |       |

Can any or all of the above activities be met using the on-call service? [ ]  Yes [ ]  No

If ‘yes’, would the identified support need be met using:

Monitoring service [ ]

Day on-call [ ]

Night on-call [ ]

Day and night on-call [ ]

If a monitoring or on-call service is appropriate, provide clinical reasoning for how the client/worker’s needs will be met

|  |
| --- |
|        |

Comments about personal care activities, including (where relevant) strategies to maximise independence and the client/worker’s anticipated future level of function

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| --- |
|       |

1. Domestic activities *(including household tasks and gardening)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Functional level** | **Type of assistance required** | **Support type** | **Is client/worker’s status likely to change?** | **Current hours** | **Recommended hours** |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|  |  |  |  | Total |       |       |

Comments about domestic activities including (where relevant) strategies to maximise independence and the client/worker’s anticipated future level of function

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|       |

Comment on size of house/garden and whether the client/worker owns appropriate equipment, *e.g. lawn mower*

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1. Capacity of attendant carer to overlap/combine duties

*(i.e. comment on potential of overlapping tasks such as making the bed/tidy bathroom while client/worker is toileting)*

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|       |

D. Other household members

Comment on other household members’ usual and current duties and their ability to assist with ADL tasks

|  |
| --- |
|       |

|  |  |  |
| --- | --- | --- |
| Date home services reviewed |       /       /       |  |

1. Community activities (include recreation, leisure and community access)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Functional level** | **Type of assistance required** | **Support type** | **Is the client/worker’s status likely to change?** | **Current hours** | **Recommended hours** |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|  | Total |       |       |

Comments about community status and community supports available. Including (where relevant) strategies to maximise independence and the client/worker’s anticipated future level of function

|  |
| --- |
|       |

1. Other activities, *e.g. vocational/occupational rehabilitation, education, therapy support and self-management* activities

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Activity** | **Functional level** | **Type of assistance required** | **Support type** | **Is client/worker’s status likely to change?** | **Current hours** | **Recommended hours** |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|       |       |       |       | [ ]  Yes [ ]  No |       |       |
|  | Total |       |       |

Comments about vocational/occupational rehabilitation, education, therapy support and self-management status

|  |
| --- |
|       |

1. Overnight care and daily welfare check

Are you recommending any level of overnight support? [ ]  Yes [ ]  No

Provide details of the client/worker’s identified overnight care needs

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|        |

|  |  |
| --- | --- |
| Can the client/worker’s overnight care needs be met with a personal alarm/monitoring service? [ ]  Yes [ ]  NoIf ‘yes’, does the client/worker also require a daily welfare check? [ ]  Yes [ ]  NoCan the client/worker’s overnight care needs be met with the on-call service? [ ]  Yes [ ]  No |   |

Please provide the clinical reasoning to support your recommendation for the on-call service and detail the support required

|  |
| --- |
|       |

1. Are you requesting sleepovers? [ ]  Yes [ ]  No

Please provide clinical justification for sleepovers and why the client/worker’s support needs cannot be met using the on-call service

|  |
| --- |
|       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Number of sleepover nights required/ week |  |       |  |  |
| Active hours per night |  |       |  | Inactive hours per night |  |       |

Comments about assistance required, *e.g. turning required at night*

|  |
| --- |
|       |

Provide details of alternatives to 1:1 sleepovers that you have considered *(e.g. gratuitous care, equipment, etc.)*

|  |
| --- |
|       |

1. Supervision and safety

Please detail recommendations for supervision. Explain the purpose *(e.g. support for a task or activity)* and detail the perceived or potential for harm/risk that the supervision is preventing. Include clinical reasoning and alternatives considered, where relevant. Please indicate where the supervision being recommended **IS NOT** directly related to an activity or a task.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** | **Perceived harm/risk** | **Has an alternative to supervision been considered?** | **Describe the alternative considered** | **Describe why supervision is more appropriate** |
|       |       | [ ]  Yes [ ]  No |       |       |
|       |       | [ ]  Yes [ ]  No |       |       |
|       |       | [ ]  Yes [ ]  No |       |       |
|       |       | [ ]  Yes [ ]  No |       |       |
| Total hours of supervision being requested |       hours |

1. Proposed weekly planner

Please indicate where TAC/WorkSafe funded supports are used during the week, including attendant care, therapy support, community group programs, etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Morning** | **Afternoon** | **Evening** | **Total hours per support type per day** |
| **Example** | **e.g.** *7 – 9 am PC (bowel care, showering* *dressing): 2 hours*  *9 – 10 am Therapy Support:*  *(stretching) 1 hour*  | **e.g.** *1 – 3 pm domestic services: 2 hours*  *3 – 4 pm Transport, shopping:*  *CA - 1 hour* | **e.g.** *6 – 7 pm personal care (dinner* *preparation): 1 hour* | **e.g.**  *PC: 3 hours* *CA: 1 hour*  *TS: 1 hour* *DS: 2 hours* |
| **Monday** |       |       |       |       |
| **Tuesday** |       |       |       |       |
| **Wednesday** |       |       |       |       |
| **Thursday** |       |       |       |       |
| **Friday** |       |       |       |       |
| **Saturday** |       |       |       |       |
| **Sunday** |       |       |       |       |
|  | **Total hours for week** |       |

1. Comments, summary and recommendations

|  |
| --- |
|       |

1. Equipment and/or modifications required

Please detail any recommended equipment. Include details of all equipment trialled, including the specific item you are recommending.

* Check with the TAC/WorkSafe contracted equipment suppliers for your recommended equipment. If the equipment is not available from the contracted equipment panel then attach a quote to this report
* Refer to the TAC/WorkSafe equipment policy for more information.

Please note that the TAC/WorkSafe may request Assessor services in accordance with the Equipment Assessment Services contained in the contract.

|  |  |  |
| --- | --- | --- |
| **Equipment and supplier details***e.g. Light-weight lawn mower* | **Length and location of trial***e.g. 1 week at home* | **Clinical justification, findings and impact of equipment on need for home services** *e.g. Client unable to operate existing lawn mower due to pain.**Trial of lightweight lawn mower was successful. Enables client/worker to mow lawn independently and reduce the need for gardening services* |
|       |       |       |
|       |       |       |
|       |       |       |

1. **Assessor follow-up services**

The TAC/WorkSafe Agent is able to approve a maximum of 6 hours to provide follow–up services.

|  |  |  |
| --- | --- | --- |
| **Explain why follow-up services or training are recommended** | **Frequency and duration of follow-up services, *e.g. Weekly follow-up for 2 months*** | **Comments, *including additional travel time***  |
|       |       |       |
|       |       |       |
|       |       |       |

Is a referral for further occupational therapy services required?
 **[ ]**  Yes **[ ]** No

Referral isrequired if follow-up is anticipated to be greater than 6 hours. If ‘yes’, please outline the areas that need to be addressed

|  |
| --- |
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1. Discussion with treating healthcare professionals

Provide the outcomes of the discussions you have had with the treating healthcare professionals about your recommendations. Include any differences in opinion or support for your recommendations

|  |
| --- |
|       |

12. Additional comments/other attached information

|  |
| --- |
| [ ]  Other attached information or additional comments, please specify       |
|  |

Assessor Occupational Therapist details

|  |  |  |
| --- | --- | --- |
| Provider name, address and phone no. *Use practice stamp where possible* |  | Signature |
|       |  |  |
|       |  |  |
|       |  | Days/hours available |
|       |  |       |
|       |  | Date |
|       |  |      /     /      |

13. Personal and Health Information

TAC

The TAC will retain the information provided and may use or disclose it to make further inquiries or assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law to disclose this information. Without this information the TAC may be unable to determine entitlements or assess whether treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website atwww.tac.vic.gov.au

**WorkSafe**

Personal and health information collected by WorkSafe and WorkSafe Agents on this form is used for the purpose of processing, assessing and managing claims under Victorian workers compensation legislation. It may also be used for other related purposes including legal proceedings arising under legislation, to assist with a worker’s rehabilitation and return to work and to assist WorkSafe and its Agents to better manage claims generally.

For the purposes of processing, assessing and managing a claim, WorkSafe and the Agent of the injured worker’s employer may disclose personal and health information about the worker to each other and to the following types of organisations:

* employees, contractors and agents of WorkSafe and WorkSafe Agents;
* employers of the injured worker;
* solicitors, medical practitioners and other health service providers, private investigators, loss adjusters and other service providers acting on behalf of WorkSafe or the Agent in relation to the claim;
* the Accident Compensation Conciliation Service and Medical Panels;
* a court or tribunal in the course of criminal proceedings or any proceedings under any of legislation which WorkSafe administers;
* any other person, organisation or government agency authorised by you, or by law, to obtain the information.

An individual may request access to personal and health information about them collected by WorkSafe or an Agent by contacting the Agent.

WorkSafe's Privacy Policy is available at the nearest WorkSafe office or at [www.worksafe.vic.gov.au](http://www.worksafe.vic.gov.au)