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 16 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:  |       |  |       /       /       |  |       /       /       |

2. Assessment Scope

|  |  |
| --- | --- |
| Modifications to existing vehicle/car only  | [ ]  |
| Contribution to new/second hand vehicle/car | [ ]  |
| Contribution to new/second hand vehicle/car and modifications | [ ]  |

3. Client/worker’s anticipated driving status

|  |  |
| --- | --- |
| Client/worker as a driver  | [ ]  |
| Client/worker as a passenger | [ ]  |

If client/worker is a driver

|  |  |
| --- | --- |
| Licence category *specify e.g. car, motorcycle etc* |       |
| Current licence | [ ]  Yes [ ]  No |
| Restricted licence  | [ ]  Yes [ ]  No |
| Has the client/worker had a driving assessment by a VicRoads authorised driving occupational therapist? | [ ]  Yes [ ]  No |
| *If yes, please provide OT contact details* |        |

**4. Background information and transport accident/work related injury**

a. Injury details

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

|  |
| --- |
|       |

**b. Details of any pre injury conditions**

|  |
| --- |
|       |

c. Outline the client/worker’s vehicle/car usage pre injury

Detail the frequency and purpose of vehicle/car use, e.g. four days a week to attend school/work.

|  |
| --- |
|       |

d. Outline the client/worker’s current and anticipated future vehicle/car needs

 Detail the frequency and purpose of vehicle/car use, e.g. four days a week to attend school/work.

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4. Current vehicle/car

In order for the TAC or WorkSafe Agent to determine reasonable contribution, please outline the details of client/worker’s current or pre injury vehicle/car. Please provide details of other vehicle/cars the client/worker has access to.

|  |  |  |
| --- | --- | --- |
|  | **Client/worker’s current vehicle/car** | **Client/worker’s pre-accident/work injury vehicle/car** |
| Make & model |       |       |
| Year of manufacture |       |       |
| Current kms |      kms |      kms |
| Engine capacity (1.5L, 2.0L) |      L |      L |
| Type of transmission (auto or manual) |  |  |
| Year of purchase  |       |       |
| Is the vehicle/car owned/leased or rented?  |       |       |

Other vehicle/cars that the client/worker has access to

|  |  |  |  |
| --- | --- | --- | --- |
| Make & model |       |       |       |
| Year of manufacture |       |       |       |
| Current kms |      kms |      kms |      kms |
| Engine capacity (1.5L, 2.0L) |      L |      L |      L |
| Type of transmission (auto or manual) |  |  |  |
| Year of purchase |       |       |       |
| Market value of vehicle/car |       |       |       |
| Is the vehicle/car owned/leased or rented? |       |       |       |

How often does the client/worker have access to these vehicles/cars?

*Outline reasons for limited access, if applicable*

|  |
| --- |
|       |

Are any of the above specified vehicles/cars currently available and suitable for installation, adaptive equipment or structural alterations? [ ]  Yes [ ]  No

*If no, please provide rationale below*

|  |
| --- |
|       |

5. Transport needs

Please indicate relevant others and items required to be transported in this vehicle/car now and in the future. *Please include predicted needs if client/worker’s needs are expected to change in the future. Consider equipment that has been provided/awaiting prescription or is yet to be investigated.*

|  |  |  |
| --- | --- | --- |
|  | **Current status** | **Anticipated future status** |
| People: number and relationship of people who would be using the vehicle/car on a regular basis apart from the client/worker *e.g. family, attendant carers* |       |       |
| Please detail the equipment to be transported on a regular basis (i.e. day-to-day) for the client/worker: *e.g. ramps, wheelchair, scooter, mobile hoist, gait aids* |       |       |
| Other |       |       |

6. Wheelchair specifications

If applicable, please outline the details of all wheelchairs the client/worker will be seated in when travelling or transferring from/into vehicle/car

|  |  |  |
| --- | --- | --- |
| Manual (folding/rigid frame) [ ]  |  Power [ ]  | Type & model:       |
| Wheelchair footprint. *Overall dimensions when client/worker sitting in wheelchair in usual travel posture and with accessories/medical equipment attached.* *Include diagram if appropriate* |
| Width |       |
| Length |       |
| Floor to eye height |       |
| Floor to top of head |       |
| Floor to seat height |       |
| Floor to footplate height |        |
| Castor/wheel size |       |

|  |  |
| --- | --- |
| Is the client/worker’s current vehicle/car able to have recommended adaptive equipment and structural modifications installed? |  [ ]  Yes [ ]  No  |

7. Recommended vehicle/car adaptations

*Please outline rationale for all recommendations and where relevant outline any goals outlined by the client/worker and assessor.*

|  |  |
| --- | --- |
| When travelling in the vehicle/car, client/worker is to be: | **Comments**  |
| Driver seated in wheelchair | [ ]  |       |
| Driver seated in vehicle/car seat | [ ]  |       |
| Passenger seated in wheelchair | [ ]  |       |
| Passenger seated in vehicle/car seat | [ ]  |       |
|  |  **Clinical Justification** |
| a) Wheelchair access into and within vehicle/car (rear/side, dimensions) |       |
| b) Vehicle/car seating arrangements i.e*. Where will client/worker sit in vehicle/car? Other seats required in vehicle/car?* |       |
| c) Is specific seating required  *i.e. seat belts,* *special seats, head supports* |       |
| d) Are modified controls required *e.g. left foot accelerator, hand controls* |       |
| e) Are specific vehicle/car options required *e.g. transmission type* |       |
| f) Features required for wheelchair dimensions *i.e. door openings, dimensions, ramps, restraints, wheelchair hoist* |       |
| g) Other |       |

**Are you requesting the TAC/WorkSafe to contribute to a new/second hand vehicle/car?** [ ]  Yes [ ]  No

Detail any trials completed including the date, location and outcome of the trial.

Comment on the similarity of the trial vehicle/car to the identified vehicle/car modifications and/or alternative vehicle/car.

|  |
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|       |

8. Alternate vehicle/cars and modifications

Please provide details of vehicle/cars and modifications that will meet the client/worker’s needs as out lined in question 7. Include the vehicle/cars that are suitable for the requested conversion, the type of conversion requested, quotes\* and the name of companies that are able to do the conversion requested.

|  |
| --- |
|       |

*\* Please ensure quotes are itemised*

If structural alterations are recommended have you discussed these proposed alterations with a VASS certified engineer and obtained written advice that a vehicle/car with such structure alterations is registrable*? e.g. If structural alterations will result in a vehicle/car with 5cm ground clearance, VASS advice is required to confirm that the vehicle/car with the 5cm ground clearance is registrable.* [ ]  Yes [ ]  No

**Comments**

|  |
| --- |
|       |

9. Vehicle/car availability

Have you discussed with the client/worker the need to ensure that the modified vehicle/car is readily available for the client/worker’s use?
*I.e. the vehicle/car must be free for use when the client/worker requires it and parked where the client/ worker/carer can readily access it.* [ ]  Yes [ ]  No

**Comments**

|  |
| --- |
|       |

10. Parking

Has an appropriate location for parking been established which provides adequate space for transfers, ramps/hoists, driving wheelchair around the vehicle/car, loading wheelchair from rear/side entry or on top of vehicle/car? [ ]  Yes [ ]  No

**Comments**

|  |
| --- |
|       |

Have underground car parks that the client/worker regularly accesses, eg. Local shopping centre or cinema, been checked to ensure that the modified vehicle/car will be able to access these space with all the equipment fitted? [ ]  Yes [ ]  No

**Comments**

|  |
| --- |
|       |

11. Insurance and registration

**Has the client/worker been made aware that he/she will be required to pay for the following?**

|  |  |
| --- | --- |
| Comprehensive insurance and any excess incurred by client/worker/carers in case of an accident  |  [ ]  Yes [ ]  No |
| TAC levy/registration fee |  [ ]  Yes [ ]  No |
| Any additional options to the vehicle/car not required due to injuries  |  [ ]  Yes [ ]  No |
| Maintenance and repair of vehicle/car |  [ ]  Yes [ ]  No |
| Fuel |  [ ]  Yes [ ]  No |
| Other vehicle/car running costs, e.g. oil, tyres |  [ ]  Yes [ ]  No |
| Road Rescue  |  [ ]  Yes [ ]  No |

Additional comments

|  |
| --- |
|       |

**12. Assessor follow-up services**

Detail the specific follow-up actions that are required to facilitate the achievement of goals and recommendations identified in section 7. The clinical justification for these services should be clear from your recommendations. Detail the number, frequency and duration of follow-up services requested.

|  |  |  |
| --- | --- | --- |
| **Details of follow-up actions or training recommended** | **Frequency and duration of follow-up services** | **Comments including additional travel time required for assessor and associated request**  |
|       |       |       |
|       |       |       |
|       |       |       |

Is a referral for further occupational therapy services required?

If yes, please outline the areas that need to be addressed

|  |
| --- |
|       |

13. 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

|  |
| --- |
|       |

14. Additional comments

|  |
| --- |
|       |

**15. Checklist:**

[ ]  Attached quotes

[ ]  Attached other information; please specify ­­­­­­­­­­­­

Assessor Occupational Therapist details

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

16. 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

**WorkSafe**

Personal and health information collected by WorkSafe on this form is used for the purpose of processing, assessing and managing claims under the *Accident Compensation Act 1985* (the Act). It may also be used for other related purposes including legal proceedings arising under the Act, 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 the Acts 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)