



Te Kaporeihana Āwhina Hunga Whara

## Clinical Services Assessment Report and Treatment Plan (CSARTP)

Please complete the form and sign the declaration. Keep this form for your records and send a copy along with any supporting documents to ACC as follows:

- Prior approvals requests: [prior.approval@acc.co.nz](mailto:prior.approval@acc.co.nz)
- All other CSARTPs: [clinical.notes@acc.co.nz](mailto:clinical.notes@acc.co.nz)

Please tick box to indicate if this is an:

Initial Plan

Updated plan

Prior Approval request

### 1 . ACC DETAILS

This form was completed on [date]

Email address:

### 2. SUPPLIER DETAILS

Supplier name:	Supplier number:
Specialist's name:	Date of consultation:
Specialist Email address:	

### 3. CLIENT DETAILS

Client's full name:
ACC Claim number:

### 4. CONSULTATION DETAILS

Injury details (including date and history of the injury, the initial and current diagnosis, and relevant medical history)	
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### 5. TREATMENT RECOMMENDED

ACC procedure code	
ACC procedure name	
Date of proposed treatment	
Activity modification (eg light duties)	

Proposed plan	
Review date (anticipated or known)	

**6. ATTACHMENTS**

Please list and attach copies of any documents that support your recommendations

**7. SPECIALIST DECLARATION**

I certify that, on the date shown, I personally examined and/or treated the client. I have discussed their treatment options with them and advised why the recommendation is the appropriate treatment in this case. The client (or their representative) has authorised me to provide this information to ACC on their behalf.	
Signature:	Date:
Specialist name:	

The information collected on this form will only be used to fulfil the requirements of the Accident Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Health Information Privacy Code.