ACC completes this form to refer a client for a Pain Management Triage assessment.

Refer to the information on this form and attached documents to complete the triage. Please quote purchase order number [purchase order number auto] when invoicing ACC for this service.

|  |
| --- |
| 1. Client details |
| Client name: [Client full name auto]  | ACC claim number: [Claim number auto] |
| Date of birth: [Client dob auto]  | NHI number: [Client NHI num auto] |
| Email address: [Client email address auto] | Ethnicity: Client ethnicity auto] |
| Phone number: [client home ph auto] | Mobile phone: [client mobile ph auto] | Work phone: [client work ph auto]  |
| Residential address: [client address auto] |
| Postal address (if different from above):       |

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| 2. Vendor details  |
| Vendor name: [vendor name auto] | Vendor contact: [attn to auto] |
| Phone number: [vendor phone no auto] | Email address: [vendor email auto] |

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| 3. Services approved |
| Service code | Service description | From | To  |
| [serv code auto] | [service description auto] | [from auto] | [to auto] |

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| 4. Injury details |
| How did the accident happen (mechanism of injury)? [Injury – Accident auto] | Date of injury: [DOI auto] |
| Read code | Description | Side | Site |
| [Read code auto] | [Description auto] | [Injury side auto] | [Injury site auto] |
| Additional supporting information (if needed):       |

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| 5. Client work details and rehabilitation goals |
| Main pre-injury daily activity(s):  | [ ]  Employee/self-employed [ ]  Child [ ]  Student [ ]  Retired [ ]  Unpaid care-giver/parent [ ]  Unemployed [ ]  Other:        |
| Pre-injury employment type: | [ ]  Full time | [ ]  Part time  | [ ]  Other:       |
| Job title and organisation:       |
| Vocational rehabilitation goal: [ ]  Return to their pre-injury job (either full or part time)[ ]  Return to work in a different job (either full or part time)  |
| Rehabilitation goals agreed by the client and ACC: [insert recovery plan goals] |
| Known barriers or special considerations | Existing or recommended support |
| [ ]  Cultural or language considerations |       |
| [ ]  Substance misuse  |       |
| [ ]  A previous disorder of persistent pain |       |
| [ ]  A previously diagnosed somatic symptom disorder or history of unexplained medical symptoms  |       |
| [ ]  A history of mental health disorder/illness |       |
| [ ]  On current medication |       |
| [ ]  Other:  |       |
| [ ]  Any known risks: |       |

|  |  |
| --- | --- |
| 6. Relevant contact details |  |
| Role  | Contact person’s name | Phone number | Email address | Summary of current support |
| General Practitioner |       |       |       |       |
| Employer |       |       |       |       |
| Specialist |       |       |       |       |
| Vocational Rehabilitation provider |       |       |       |       |
| Physiotherapist |       |       |       |       |
| Psychologist |       |       |       |       |
| Other:       |       |       |       |       |

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| 7. Additional comments |
| Other relevant information about this client’s case. |
|       |

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| 8. ACC contact details |
| ACC Recovery Team Member:       | Contact phone number:       |
| Email address:       |

View our privacy disclaimer at [acc.co.nz/privacydisclaimer](https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.acc.co.nz%2Fprivacy%2Fprivacy-disclaimer%2F&data=05%7C01%7CAaron.Belsham%40acc.co.nz%7C0e4613e7747b41cd891c08da4f4759ce%7C8506768fa7d1475b901cfc1c222f496a%7C0%7C0%7C637909465114726322%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=kczSoigwBYethFlk3XVCIzkhZlN0LhPaynbWH%2B9SYEY%3D&reserved=0)