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): | | | |

|  |  |
| --- | --- |
| 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] |

|  |  |  |  |
| --- | --- | --- | --- |
| 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): | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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: | |  | | |

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| --- | --- | --- | --- | --- | --- |
| 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: |  |  |  |  | |

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

|  |  |
| --- | --- |
| 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)