Please complete this form to let us know about this client’s triage assessment, the conclusions regarding the likely diagnosis/es and cause/s and the proposed clinical care pathway.

When you’ve finished, please send a copy to the ACC recovery team member managing the Claim or to [Claims@acc.co.nz](mailto:Claims@acc.co.nz) if you are unsure of the Recovery Team Member/Recovery Team.

|  |  |
| --- | --- |
| 1. Client details | |
| Client name: | |
| Address: | |
| Claim number: | Date of birth: |

|  |  |
| --- | --- |
| 2. Vendor details | |
| Supplier name: | Vendor number: |
| Phone number: | Vendor email address: |

|  |  |
| --- | --- |
| 3. Confirmation of suitability for the Pain Management Service | |
| **Recommendation:**  *Note: Choose Group Programme when required, and/or* ***one*** *of the following Community Level 1, Community Level 2 or Tertiary if required*  Rationale for any recommended Pain Management Service is provided in the Summary of Findings in Section 4. | Not suitable for a Pain Management service (see below)  Group Programme  Community Services Level 1  Community Services Level 2  Tertiary Delivery Services |
| **If the client is not suitable for the Pain Management Service, please explain why and any recommendations on what support or alternative service the client needs:**    **For clients who are recommended for the Pain Management Service, do they meet the eligibility criteria?**  Not applicable, the Pain Management Service is not recommended  Yes, the client meets the eligibility criteria for the recommended Pain Management Service level  No, please provide clinical rationale as to why the Client would benefit from a Pain Management service despite not meeting the eligibility requirements. | |

|  |  |  |
| --- | --- | --- |
| 4. Triage report | | |
| Description of the client’s history  *Include information on previous persistent pain, mental health conditions, substance misuse and any underlying conditions* | | |
|  | | |
| Summary of Findings  *Include an evaluation of all possible causes and contributors to the pain/s. Describe the relationship between the pain the Client is experiencing, and the ACC covered injury. Include information about the Client’s cultural considerations, values, and beliefs. This section should provide rationale for the recommended Pain Management Service in Section 3 and estimated timeframes of service.* | | |
|  | | |
| List of medicines | | |
|  | | |
| Summary of ePPOC results | | |
|  | | |
| Triage Clinician: | | Discipline: |
| Any other Triage clinician: | | Discipline: |
| Date of Triage: | | Date of IDT Review: |
| IDT member |  | Discipline: |
| IDT member |  | Discipline: |

|  |  |
| --- | --- |
| 5. Declaration and signatures | |
| I certify that:   * I have personally examined and/or treated the client. * I have discussed the recommendations I have made in this report and the rationale for these with the client and other provider/s who have performed the triage and case review. * The client (or their representative) has authorised me to provide this information to ACC. | |
| Name of Triage clinician: | |
| Signature: | Date: |

When we collect, use and store information, we comply with the Privacy Act 2020 and the Health Information Privacy Code 2020. For further details see ACC’s privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.