A Back to Work (BTW) provider completes this form to update ACC on a client’s progress towards their return-to-work rehabilitation.

Submit this form to the ACC contact person or claims@acc.co.nz

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| 1. Report stage |
| **[ ]  Initial***Complete sections 1 to 7 and sign section 9* | **[ ]  Progress** (number):       of      *Additionally complete section 8 and sign section 9. Only the current progress report is required.* | **Date of this report:**       |

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| 2. Client details |
| **Client name:**       | **Claim number:**       |
| **Date of injury:**       |

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| 3. Supplier Contact details |
| **Supplier company name:**       | **Service Delivery Company name:**       |
| **Lead Provider name:**       | **Lead Provider phone:**       |
| **Lead Provider email address:**       |

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| 4. Overall objectives |
| What is the overall objective specified in the referral? *You may tick more than one* |
| **Regain fitness for Pre-injury Work Role:***Please also complete section 6a* | [ ]  | **Work readiness for Vocational independence (VI)***Please also complete section 6b* | [ ]  |
| **Obtain employment** | [ ]  | **Other** | [ ]  |
| **Comment:**       |

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| 5. Relevant contacts involved in the client’s rehabilitation *add lines as required* |
| Name of person | Role | Email | Phone | Date of contact |
|       |       |       |       |       |
|       |       |       |       |       |

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| 6. Initial assessment |
| **Date of initial assessment:**       | **Outcome target date on referral:**       |
| **Outcome target date following assessment:**       |
| **If applicable, the reason for the new target date:**       |
| **Assessment summary of the Client** |
| **Brief injury history**      |
| **Functional presentation / limitations**      |
| **Medical certificate status**      |
| **Biopsychosocial, cultural, and other factors (including barriers)**      |

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| 6a. Pre-Injury Work Role *Please complete this section if the objective includes regaining fitness for the pre-injury role* |
| **Has an assessment of the Client’s pre-injury work role been completed previously?**  | **[ ]**  Yes*SAW or WSA Report Date*:  | **[ ]**  No*Please complete the pre-injury role assessment below* |
| **Pre-injury role title**      |
| **Pre-injury role normal working hours/days**       |
| **Pre-injury role work tasks**      |
| **Pre-injury role physical and cognitive demands**      |
| **What rehabilitation does the Client require to regain fitness for this role?** |
|       |

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| 6b. Work readiness for Vocational independence (VI) *Please complete this section if the objective includes achieving work readiness for VI* |
| **Has an IOA/IMA been completed?** | **[ ]**  Yes | **[ ]**  No |
| **If no, is an IOA/IMA recommended?** *i.e. the outcome is unlikely to be regaining fitness for the pre-injury role* | **[ ]**  Yes | **[ ]**  No |
| **If completed, list the work types assessed as medically sustainable, or likely to be, from the IMA and the vocational rehabilitation needs identified.** |
|  |  |
| **Work Type** | **Vocational rehabilitation needs (from IOA/IMA) specific to each work type** | **Agreed to be supported by ACC** |
|       |       | **[ ]**  Yes |
| **[ ]**  No / N/A |
| **[ ]**  To be advised |
|       |       | **[ ]**  Yes |
| **[ ]**  No / N/A |
| **[ ]**  To be advised |
|       |       | **[ ]**  Yes |
| **[ ]**  No / N/A |
| **[ ]**  To be advised |
|       |       | **[ ]**  Yes |
| **[ ]**  No / N/A |
| **[ ]**  To be advised |
| **Other non-specific rehabilitation required, or barriers to be addressed, to achieve work readiness:**       |

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| 7. Activities to help achieve the overall objective |
| **List of proposed activities to meet the rehabilitation requirements as listed in 6a and/or 6b** | **Proposed completion date of the activity** |
|       |       |
|       |       |
|       |  |
| **Is a Work Specific Functional Rehabilitation required as part of this service?** | **[ ]**  Yes | **[ ]**  No |
| **If yes, provide the reason for why programme is required:**       |

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| 8. Progress report |
| Please provide a progress update to ACC and/or make a request for further services. |
| **Date of report:**       | **Progress report number:**       of       |
| **Has a functional programme been provided?** | **[ ]**  Yes | **[ ]**  No |
| **If yes, complete the table below** |
| **Work Specific Task / Requirement** | **Client’s current ability to undertake the task** | **Specific functional activities to be undertaken** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Progress since the previous report** *Please state progress towards overall objectives, whether the timeframes set in the initial report are still going to be met. If not, what are the new timeframes and why have these changed.* |
|       |
| **Has a work trial been obtained for the Client?**  | **[ ]**  Yes | **[ ]**  No | **[ ]**  Not Required  |
| **If yes, please provide details:**       |
| Dates | Days to work  | Hours per day | Work tasks  | Details of restrictions and rehabilitation  |
|       to        |       |       |       |       |
|       to       |       |       |       |       |
|       to       |       |       |       |       |
| **Has the client’s medical practitioner approved the work trial or return-to-work plan? (If yes, please attach a copy to the report)** | **[ ]**  Yes | **[ ]**  No |
| **If no, please state why:**       |
| What further service level is being requested? |
| [ ]  No further service required | [ ]  BTW 2*no prior approval required* | [ ]  BTW 3 (VRB13) | [ ]  BTW Exceptional (VRB14) | [ ]  BTW Initial Functional Rehab (VRB24) | [ ]  BTW Follow up Functional Rehab (VRB25) | [ ]  Other      |
| **Please provide a detailed reason for requesting additional services:**       |
| **List of additional activities**  | **Proposed completion date of the activity**  | **Detail the outcome of the activity and how this will achieve the overall objective** |
|       |       |       |
| **Any other comments:**       |

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| 9. Provider declaration and signature |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete. |
| Provider name:       | Provider discipline:       |
| 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](https://aus01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.acc.co.nz%2F&data=04%7C01%7CSonia.DeLautour%40acc.co.nz%7Cf3a57126063245d3c61608d8708c27c8%7C8506768fa7d1475b901cfc1c222f496a%7C0%7C0%7C637383094545478020%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=2AC5zj72t8zqZ6QVZvnU5gV1azY96dySBL%2FjWbj2uac%3D&reserved=0). We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.