If you’re a Pathways to Employment (PTE) provider, please complete this form when you need to update us on our client’s progress on their PTE programme. Please tick below to indicate which type of report this is and complete the appropriate sections.

[ ]  Initial Report

Complete sections 1 to 7 and sign section 9

[ ]  Progress report

Complete sections 1 to 5, 8 and sign section 9. (Only current progress report required)

When you’ve finished, please send a copy to the ACC contact person.

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| 1. Report stage |
| Initial:        | Progress (number):       | Date of this report:       |

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

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| 3. Contact details |
| Lead supplier company name:        | Lead supplier contact name:       |
| Treatment provider company name:       |
| Treatment provider name:       | Treatment provider email address:       |
| ACC contact name:       | ACC contact person email address:       |

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| 4. Overall objectives |
| What is the overall objective specified in the referral?  |
| Same job, same employer | [ ]  | Similar job, new employer | [ ]  |
| Modified job, same employer | [ ]  | Modified job, new employer | [ ]  |
| New job, same employer | [ ]  | New job, new employer | [ ]  |
| Work ready and vocationally independent | [ ]  | Maximum employment participation. | [ ]  |

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| 5. Relevant contacts for the treatment provider involved in the client’s rehabilitation |
| Name of assessor/contact person | Contact details | Date of contact |
|       |       |       |
|       |       |       |

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| 6. Initial assessment |
| Date of initial assessment:       | Target date       |
| Does this differ from the referral?       | **[ ]**  Yes | **[ ]**  No |
| If yes, please advise why:       |
| Summarise your assessment of this client |
|       |
| Barriers and opportunities identified at assessment |
|       |

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| 7. Activities to help achieve the overall objective |
| List of initial activities  | Activity Completion date | Expected outcome of activities and how they will achieve the overall objective |
|       |       |       |
|       |       |       |
|       |       |       |
| Based on the job options identified in the IOA/IMA did these interventions address all barriers to achieve the outcome? | **[ ]**  Yes | **[ ]**  No |
| Is related information attached? | **[ ]**  Yes | **[ ]**  No |
| If yes, please give details:       |
| Other comments:       |
| Has Work Specific Functional Rehabilitation been provided as part of this service? | **[ ]**  Yes | **[ ]**  No |
| If yes, please provide detailed information on what was provided:       |

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| 8. Progress report |
| Please provide a progress update to ACC and/or make a request for further services or work specific functional rehabilitation |
| Date of report:       | Progress report number:       |
| Progress since previous report:       |
| Current return to work target date:       |
| Has the return to work target date changed?       | **[ ]**  Yes | **[ ]**  No |
| If no, please give details as to why:       |
| 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 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? |
| [ ]  PTE 2 | [ ]  PTE 3 | [ ]  PTE Exceptional | [ ]  PTE Initial Functional Rehab | [ ]  PTE Follow up Functional Rehab |
| Provide your clinical rationale for requesting additional services:  |
| Covered Injury: Co-morbidities: Whānau/Friends: Engagement: Collegial Support:  | [ ]  Low [ ]  Med [ ]  High[ ]  Low [ ]  Med [ ]  High[ ]  Low [ ]  Med [ ]  High[ ]  Low [ ]  Med [ ]  High[ ]  Low [ ]  Med [ ]  High  | Job Satisfaction: Employer Attitude: Return to Work expectations:Workplace Supportiveness: | [ ]  Low [ ]  Med [ ]  High[ ]  Low [ ]  Med [ ]  High [ ]  Low [ ]  Med [ ]  High [ ]  Low [ ]  Med [ ]  High  |
| Please provide a detailed reason for the selection above:       |
| If there are any other factors not included in the above, please give details:       |
| List of added activities | Activity completion date | Expected outcome of activities and how they will achieve the overall objective |
|       |       |       |
|       |       |       |
| Additional clinical rationale for Initial or Follow up Functional Rehab |
|       |
| Service activities required to achieve a return to work  |
| Worksite visits:       | Case Conferences:       |
| Start date:       | End date:       | Number of weeks:       |

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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:       |
| 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.