A Stay at Work (SAW) provider completes this form to update ACC on a client’s progress towards returning to their pre-injury work.

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:**       | **Client email:**       |

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

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| 4. Overall objectives |
| What is the overall objective specified in the referral?  |
| Same job, same employer | [ ]  | Modified job, same employer | [ ]  |
| New job, same employer | [ ]  | 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:**       | **Return to work target date on referral:**       |
| **Return to work target date following assessment:**       |
| **Clinical reason for the new target date:**       |
| **Return to Work Plan:** |
| **Dates** | **Days to work** | **Hours per day** | **Work tasks** | **Details of restrictions and rehabilitation** |
|       to       |       |       |       |       |
|       to       |       |       |       |       |
|       to       |       |       |       |       |
|       to       |       |       |       |       |
| **Assessment summary of the client and the workplace** |
| **Brief injury history and functional presentation**      |
| **Medical certificate status**      |
| **Pre-injury role title**      |
| **Normal working hours/days**       |
| **Work tasks of the role**      |
| **Physical and cognitive demands of the role**      |
| **Barriers and opportunities identified at assessment**      |

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| 7. Activities to help achieve the overall objective and address any identified barriers |
| **List of initial activities**  | **Proposed completion date of the activity** | **Detail the outcome of activity and how this will achieve the overall objective** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| **Is a Work Specific Functional Rehabilitation required as part of this service?** | **[ ]**  Yes | **[ ]**  No |
| **If yes, provide the reason the programme is required:**       |
| **If yes, complete the table below**  |
| **Work Task** | **Client’s current ability to undertake the task** | **Specific functional activities to be undertaken** |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

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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       |
| **Progress since previous report:**       |
| **Current return to work target date:**       |
| **Has the return-to-work target date changed?**  | **[ ]**  Yes | **[ ]**  No |
| **If yes, please give details as to why and update the return-to-work plan in the table below**      |
| **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 submit with the report) | **[ ]**  Yes | **[ ]**  No |
| **If no, please state why:**       |
| **Is a further service level requested?** |
| [ ]  No further service required | [ ]  SAW 2 *no prior approval required* | [ ]  SAW 3 | [ ]  SAW Exceptional | [ ]  SAW Initial Functional Rehab | [ ]  SAW Follow-up Functional Rehab | [ ]  Other      |
| **Provide a detailed reason for requesting additional services**      |
| **List of added activities** | **Proposed completion date of the activity** | **Detail the outcome of activity and how this will achieve the overall objective** |
|       |       |       |
|       |       |       |

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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.