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** | | |
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| **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.