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| **Claim Review Written Report** | | | |
| **Clinical Directors Name**: | | **Date**: | |
| **Treating Provider Name**: | | **Claim no**: | |
| **1** | **A review of the Mechanism of Injury**  ***Please explain how the reported accident event has caused the client’s injury*** | | |
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| **2** | **A review of the injury and clinical diagnosis**  ***Please confirm the client’s current injury diagnosis. If the client’s diagnosis has changed, please ask the treating provider to*** [***Complete the ACC32 application form online***](https://aus01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fforms.acc.co.nz%2FACC32%2Findex.htm&data=04%7C01%7CAlice.McBeth%40acc.co.nz%7C8ad74a6d04e64bced72b08d93c013c0c%7C8506768fa7d1475b901cfc1c222f496a%7C0%7C0%7C637606798261875792%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=WbFnbPrgLWiOPPIbD3Mr%2FSYIUnB0GRg3MYHx7YzJS%2F4%3D&reserved=0) ***explaining the rationale for the change of diagnosis*** | | |
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| **3** | **A statement on causation considering (a) and (b) above**  ***Please explain how the accident event caused the current injury diagnosis being treated*** | | |
|  |  | | |
| **4** | **A review of the current Treatment Plan**  ***Please summarise the treatment which has been provided to date and provide detailed comment on whether this was necessary and appropriate to treat the covered injury.*** | | |
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| **5** | **Documentation of any recommendations and actions that the treatment provider will need to consider (including changes to the treatment plan, onward referral or investigation)**  ***Please explain why further treatment is required and what your recommendations are to treat the covered injury.***  ***Should further investigations or an onward referral be considered at this point?*** | | |
|  |  | | |
| **6** | **Expected outcome with consideration of any recommended changes**  ***What is the expected course of recovery for the client, given your review and any recommendations? Please specify the number of treatments required over what length of time.*** | | |
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| **8** | **Liaison with provider undertaken**  ***Please detail your discussion with the treating provider following your review regarding the treatment given to date, expected course of recovery and discharge date? What was the outcome of the discussion?*** | | Confirm conversation held with Provider  Yes ☐ |
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