Initial Assessment and Treatment Request Form

Veteran's details

1 Veteran's title

☐ Mr ☐ Mrs ☐ Ms ☐ Miss Other ______

2 Veteran's full name

First name ______

Middle names ______

Family name ______

Preferred name ______

3 Date of birth: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)

4 Reference number: ______

Medical information

5 Give a detailed account of the veteran's current condition and symptoms, including your clinical opinion on their diagnosis, and any other relevant information.

6 Describe how their condition is impacting on their day-to-day life using both the veteran's self-reported limitations **and** an outcome measure or questionnaire of your choice. This can be pain-related, function-related, body-site specific, or focused on whole life health.

7 Did your assessment identify any **risks** that will affect your treatment plan?

- [ ] Yes — Please comment:
- [ ] No

Have you called the veteran's GP regarding this?

- [ ] Yes
- [ ] No

Would you like Veterans' Affairs to contact you regarding this?

- [ ] Yes
- [ ] No

8 If the veteran has been treated elsewhere before seeing you, give an outline of the veteran’s treatment so far **and** the reported effect of this previous treatment (for example physio exercises, partial recovery, complete recovery, no effect, worse).

9 What is **your** treatment plan and goals for the sessions you have requested? Include time frames to achieve this **and** outline your expectations on whether you feel these sessions will resolve the current symptoms/this episode for the veteran.

10 What are the **veteran’s** goals for themselves by the completion of these sessions?

11 If these sessions are unsuccessful in meeting your treatment plan and/or achieving the veteran’s goals, what do you feel would then be the best course of action?

Session information

12 Date of first appointment: __ __ / __ __ / __ __ __ __ (DD/MM/YYYY)

13 Cost of sessions or treatment:

14 Number of sessions requested:

15 Frequency of sessions:

Provider's information

16 GST number or Veterans' Affairs vendor number:

17 Business name:

18 Profession:

19 Phone number:

20 Email address:

21 Professional body registered with:

22 Professional body registration number:

Signature | Please sign

Provider's signature and name

Signature of provider:

Today's date: (DD/MM/YYYY)

__ __ / __ __ / __ __ __ __

First names:

Surname: