



Australian Government

Comcare

PHYSIOTHERAPY TREATMENT PLAN

PRIVACY

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Please refer to the notes for assistance in completing this form.

Lodgement of: Email: clinical.panel@comcare.gov.au Post: GPO Box 9905, Canberra 2601 Fax: 1300 196 971

TREATMENT PLAN REQUEST (please tick most appropriate)

Initial ☐ Review ☐

EMPLOYEE DETAILS

Employee name

Claim number

Date of birth

 / /

Occupation

INJURY DETAILS

Diagnosis (areas being treated, directly related to compensable condition)

WORK STATUS

Hours

Pre-injury hours at work per week

Current hours at work per week

Current duties

Pre-injury duties ☐ Not working ☐

Alternative/modified duties ☐

ASSESSMENT

Standardised outcome measures	Initial score		Review score		Review score	
	Date	Score	Date	Score	Date	Score
Risk measures	Initial score		Review score		Review score	
	Date	Score	Date	Score	Date	Score

Barriers

Specify any physical, personal and/or environmental barriers that may influence the employee's return to work and recovery.

LIST CURRENT ACTIVITY/FUNCTIONAL LIMITATIONS AND RELATED GOALS

Current activity/functional limitations	Related activity goals (include ADL and work/travel goals)	Estimated date of achievement
1.	1.	
2.	2.	
3.	3.	

PROPOSED TREATMENT PLAN

Proposed total number of services over number of weeks

From / / to / / Anticipated discharge date / /

PROPOSED TREATMENT METHODS

Treatment details

Self management—indicate strategies that the employee will use to manage their condition

TREATING PHYSIOTHERAPIST DETAILS

I currently have registration with Australian Health Practitioner Regulation Agency Yes ☐ No ☐

Name

Address Phone no

Email Days/times available

Treating Physiotherapist's signature Date / /

CONSENT

I (please print your name) hereby authorise you to supply Comcare with information requested on this form and to discuss the contents of this form and any ongoing issues of my treatment, with officers or representatives of Comcare.

Signature of employee or guardian Date / /