PREVENTION. CARE. RECOVERY.
Te Kaporeihana Āwhina Hunga Whara

11 November 2019

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Tēnā koe Karl

Your Official Information Act request, reference: 002142
Thank you for your email of 16 October 2019, asking for the following information under the Official Information Act 1982 (the Act):

1. *I would like to request a copy of the following form;*
   ACC29
   ACC6247
   ACC2222
   ACC6267

Attached are the forms you requested.

If you have any questions, you can email me at GovernmentServices@acc.co.nz

Nāku iti noa, nā

Emma Coats
Manager Official Information Act Services
Government Engagement & Support

ACC6247

Rehabilitation summary

Fill in this form to summarise how your client's rehabilitation has progressed and identify any future recommendations for their further, on-going support including if clinical advice is required. Please list all the information you provide in date order. Do not cut and paste report sections. Write 'Nil' if there is no information to enter

When you've finished, please save this form on to the client's claim record in Eos.

1. Client details

Client name: | Claim number:

Date of birth: | Date of injury:

Is the client over 63 no longer wants to participate in vocational rehabilitation and would their ongoing needs would be best managed by the LTSC Unit? ☐ No ☐ Yes

If yes, ensure the conversation is recorded in Eos and **only** complete sections 5 and 6

If no, fully complete all sections

Original diagnosis: | Date of incapacity:

Current diagnosis: | Occupation at date of incapacity:

Has an *ACC12 File Summary* been completed for this claim? ☐ No ☐ Yes

If yes, what date was the *ACC12* completed:

3. Medical details

Provide a summary of the client's current *ACC18 Medical certificate* information, ie capacity for work, barriers identified, timeframes:

What is the client's injury diagnosis and prognosis?

What medical information confirms the prognosis?

What date did the last ACC clinical advisor (BMA, BAP, other) comment on this claim?

Summarise the advisor's comment(s):

List any other covered injuries:

Summarise any other non-injury conditions or considerations, either medical or mental health-related, including a summary of considerations from provider contact and/or reporting:

Is there any outstanding treatment or recommendation(s) for treatment that the client hasn't received? ☐ No ☐ Yes

If yes, advise why the treatment didn't go ahead, who recommendedthis and when?

3. Rehabilitation details

What vocational rehabilitation has the client received?

Is there any outstanding vocational rehabilitation or recommendation(s) for vocational rehabilitation that hasn't taken place? ☐ No ☐ Yes

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es, advise why the outstanding vocational rehabilitation didn't take place, who recommended this and when?

What social rehabilitation is in place now?

Is there any outstanding social rehabilitation or recommendation(s) for social rehabilitation that hasn't taken place? No ☐ Yes

If yes, advise why the outstanding social rehabilitation didn't take place, who recommended this and when?

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4. Work capacity details

What were the client's pre-injury work tasks? Include evidence to support this, ie work assessment, *ACC188 Job task analysis* or Initial Occupational Assessment report:

Summarise the occupational physician comments on the client's current capacity for work. If there isn't any occupational physician reporting, explain what other opinion is available:

Is the client currently working, ie full-time on limited tasks, part-time or voluntary work? No ☐ Yes

If yes, how many hours per week?

How long has the client been working in this capacity?

What are the client's current work tasks?

If the client is working part-time, advise if the client has attempted to increase their hours and how this went:

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5. Communication considerations

Are there any specific client (or advocate) communication plans in place? ☐ No ☐ Y es

If yes, please provide details:

6. Comment and recommendation

Case manager comment:

Case manager signature: Date:

Team manager comment and/or recommendation:

Team manager signature: Date:

Branch manager decision regarding recommendation: D Accept D Decl ine

Branc h manager comment:

Branch Manager signature: Date:

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ACC6267

Wellington Central branch transfer

Com pl ete th is form to refer clients to the Wellington Central Branch (WCB).

1. Claim details

Client name: [Client full name auto] | Claim number: [Claim number auto]

Address: [Address Line 1 Auto], [Address Line 2 Auto], [Suburb Auto], [Town Or City Auto], [Post Code Auto]

Gender: [Gender auto] | Date of birth: [DOB auto] | Date of injury: [Date of injury auto] | Date of first incapacity:

Home phone: [Client home ph auto] | Mob ile: [Clien t mob ile au to] | Work phone: [Client work ph auto]

Present injury diagnosis:

Weekly compensation rate: Claims management staff member:

2. Reason for referral

Provide specific details as to the reason why the client has been transferred to WCB, ie how much time has been spent on the claim, what resources have been used and what departments have been contacted?

3. Case management plan of interventions

Detail the last two assessments or services the client received and current or future interventions planned.

4. Sign off

Wellington Branch Central Manager name:

Signature : | Date :

Head of Client Service Delivery name:

Signature : | Date :

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.

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Remote Claims Unit referral

Branch managers complete this form when referring a claim to the Remote Claims Unit.

(D This form is for internal information only. Do NOT upload this form to Eos.

1. CLAIM DETAILS

This form was completed on: [dd month yyy]

Clientname [Client full name]	Claimnumber: [Claim number]
Residential address [Client residential address]	Date of birth [Client DOB]
Postal address (if different from home address):	Gender:
Homephone: Mobliephon:e	Work phone:
Date of accident	Date of first incapacity.
Present injury diagnoiss:	Weeklycompensaitonrate:
Claimsmanagemensttaff member:	

2. REASON FOR REFERRAL

Providespecific details regarding what the clienthas done to warrant the transfer to RCU.

3. THREATENING BEHAVIOUR

Outlinewhythisperson cannotbemanagedbyanotherbranch. Detail specificthreatsmadeinthepastsixmonthstowardsthefollowing.	
ACC staff:	
Providers:	
Others:	
Reasons why person cannotbe managed at another branch:	
Has the client been trespased from any ACC location?	☐ Yes ☐ No
If yes, what location?	Date clientwas trespassed
Reason for trespasing client:	

4. RELEVANT HISTORY AND BACKGROUND

Providerelevantdetails about the client's police history and any background checks.
History:
Background cheks

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5. SECURITY INTERVENTIONS

Detail any interventions that have taken place in the last six months.
Police
ACC Health, Safety and Security team:
Fraud concerns (if any)

CASE MANAGEMENT PLAN OF INTERVENTIONS

Detail the last two assessments or services the client has received and any future interventions planned.

Case management plan of interventions that are currently in place

SIGN OFF

Remote Claims Unit Manager		
Name:	Signature	Date:
National Manager Health, Safety and Security		
Name:	Signature	Date:

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ACC29

File summary and overview

Fill in this form if you're a case owner and you need to transfer a claim to another branch or the Overseas Claims Unit. Upload it to the client's claim in Eos when you've finished.

1. Client details

Client name: [Client full name auto]

Claim number: [Claim number auto]

Date of birth: [Client date of birth auto]

Do they have an advocate? Yes D No

2. Injury, rehabilitation and entitlements

Injury: [Injury auto]

Date of injury (DOI): [DOI auto]

Occupation at date of injury: [Occupation at date of injury auto]

Diagnosis at time of injury:

Current diagnosis:

List the covered injuries:

Are there any significant non-injury factors that may have an effect on this claim? Yes ☐ No

If yes, put the details here:

Are there any other claims that may have an effect on this claim? ☐ Yes ☐ No

If yes, put the details here:

Is there a signed Individual Rehabilitation Plan (IRP) on file? ☐ Yes ☐ No

If yes, does it need updating? ☐ Yes ☐ No

IRP expiry date:

Outcome date:

Date of next monitoring step:

Tick the ongoing current entitlements that the client is receiving:

D Abatement	D Attendant care	D Training for independentliving (TIL)
D Child care	D Education support	D Transport for independence
D Sleepover	D Home help	D Vocational rehab, eg work trial etc:
D Weekly compensation at$ pw		D Other (specify):

If we're providing any social rehabilitation assistance, eg hours of care, education support etc, put the details here:

3. Work capacity

Date of incapacity:

Date of subsequent incapacity:

Has the client worked at all since the injury? D Yes D No

If yes, what type of work have they been doing?

Has capacity to return to their pre-injury employment been assessed? D Yes - Date: ☐ No

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ACC29 File summary and overview

If yes, list the recommendations:

What is the current ACC18 expiry date?

What is their current capacity for work shown on the ACC18?

D FUF (fully unfit for work) D FFSW (fit for some work) ☐ Fully fit

Is the client currently working? D Yes D No

Fill in this section if the client is currently working.

What is their role? | How many hours do they work?

Are they self-employed? D Yes D No

If no, who is their current employer?

Are they receiving abatement? D Yes D No

How do we find out what they earn? D payslips D ACC38s D other (specify):

Fill in this section if the client is FFSW.

Have we approached the current employer about light or alternative duties or Return to Work (RTW) on a work trial basis? D Yes D No

If yes, what was the employer's response?

If work is available, has a current workplace assessment been carried out? D Yes D No

Is active or monitored job search happening? D Yes D No

Fill in this section if the client is not currently working.

List the barriers that are preventing them from returning to either part-time or full time work, eg medical, motivation, psychosocial factors:

What skills, experience and strengths does the client have that will help them return to work?

Does any outstanding vocational rehabilitation need to be offered or completed? D Yes D No

If yes, put the details here:

4. Medical status

Has a Medical Case Review (MCR) been completed? D Yes - Date: ☐ No

Has there been a specialist medical review or assessment in the last 2 years? ☐ Yes ☐ No

What were the recommendations for future treatment and/or interventions from the medical report?

Have all the recommendations been completed? D Yes D No

If no, why not?

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ACC29 File summary and overview

Have both an Initial Occupational and Initial Medical Assessment (IOA and IMA) been completed?	☐ Yes - Date ☐ No
Are the work type options included in the Individual Rehabilitation Plan (IRP)?	☐ Yes ☐ No
Are any of the IMA job options medically sustainable?	☐ Yes ☐ No
If yes, list here:	
Has the client had any surgery?	☐ Yes ☐ No
If yes, put the details here, eg type of surgery and date(s):	
Is any surgery pending?	☐ Yes ☐ No
If yes, put the details here, eg type of surgery and date scheduled:	
Are any assessment reports or diagnostic tests pending?	☐ Yes ☐ No
If yes, put the details here:	
Are there any barriers to rehabilitation, eg pain, drugs and alcohol, literacy, other psycho/social impairment, other?	☐ Yes ☐ No
If yes, put the details here:	
If pain is a barrier to returning to work, has a pain programme been:	
• offered or discussed with the GP?	☐ Yes ☐ No
• completed?	☐ Yes ☐ No
Are there other injury related issues that need to be addressed before or at the same time as vocational rehabilitation?	☐ Yes ☐ No
If yes, put the details here:	
Please note anything that the new case manager should be aware of if it's not mentioned above, eg known information on the client's rehabilitation or other useful comments about the client:	

5. Overseas claims Fill in this section if you're transferring the claim to the Overseas Claims Unit (OCU).	
Is the client: ☐ living overseas already	☐ intending to move overseas?
Address: [Client address line 1 auto], [Client address line 2 auto], [Client address line 3 auto], [Client address postcode auto] Mailing address (if different from above):	
Home phone number:	Cell phone number:
What are the best times to contact the client by phone?	
When did they leave or when do they plan to leave New Zealand?	

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ACC29 File summary and overview

6. Summary
What are the next steps needed for the client's rehabilitation?
1: 2:
3: 4:
5: 6:

7. Your name and signature	
Case manager/team manager name: [Staff member auto]	
Signature:	Date:

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