EXERCISE PHYSIOLOGY MANAGEMENT PLAN

(Fax without cover sheet)

This plan relates to:_____ **D.O.B:** _____ **M / F**

(Workers name)

Claim No. _____ **Occupation/Job Title:** _____ **D.O.I:** _____

Diagnosis of workplace injury to which this plan relates, as per the WorkCover medical certificate: _____

_____

Insurer: _____ **Case Manager:** _____ **Fax:** _____ **Email:** _____

Referred by: _____ **Job Title:** _____ **Phone:** _____

Section 2: Exercise Physiologist's details		
Name:	Business Name:	
Address:		
Phone:	Fax:	Email:
WorkCover Provider No.:	**Management Plan No.:**	
Total consultations to be provided under this plan:	*Standard:*	*Reduced Supervision:* *Group:*
Initial assessment date: / /	Commencement date for this plan: / /	End date for this plan: / /
Exercise Physiologist's signature:	Date submitted:	Date approval advised:

Section 3: Outcome measures used to assess and monitor worker's progress throughout treatment period

Outcome Measure	Measure at initial assessment	Current measure	Anticipated outcome
Work Status			
Functional limitation(s)			

Section 4: Other costs

Travel: _____ Case Conference: _____ Other: _____

(*please specify*)

Section 5: Program outline, including identified barriers to RTW and recommended activity strategy to overcome each barrier

Program Outline:

Barrier(s):

Recommended strategy:

Section 6: Other assistance

Can the insurer assist your management in any other way – eg. Referral to a rehabilitation provider, independent consultant or medical specialist ? ☐ No ☐ Yes → please provide details below

Insurer Use	Plan approved / Plan not approved
Name:	Phone:
Signed:	Date:
Comments and/or reason for non-approval:	
Cc: NTD	**Worker agreed to plan:** Yes No