CONSENT TO TREATMENT FORM

FIRST NAME(S):		FAMILY NAME:	
MR, MRS, MS, MISS		PREFERRED NAME:	
DATE OF BIRTH:		NATIONALITY:	
STREET ADDRESS:		IWI: (optional)	
SUBURB		WORK PHONE:	
CITY :		OCCUPATION:	
POST CODE:			
HOME PHONE:		NAME OF GP:	
CELL PHONE:		PRACTICE NAME:	
E-MAIL:			

WHY CHOOSE US:
☐ GP Referral ☐ Location ☐ Signage ☐ Previous Client ☐ other:……………………………………………….
☐ Masters Hockey ☐ UC Health centre ☐ Internet ☐ Recommended – By who:………………………………

WHO REFFERED YOU :
☐ Self ☐ GP
☐ Specialist

HEALTH QUESTIONNAIRE: ***Does any of the following apply to you?***

☐ Pregnant	☐ Cardiovascular condition	☐ Hearing or sight disability
☐ HIV +. Hep C	☐ Skin Infection	☐ Intellectual disability.
☐ Physical disability	☐ Cancer (include previous)	☐ Other ………………………
MEDICATION:		

ACC OR PRIVATE (<u>Please Circle</u>)

If PRIVATE, please skip to signature / If ACC, please complete details below

Have you already completed an ACC claim form for this injury?	**YES / NO** **If YES, please supply ACC45 NO:**	**Have you had treatment with another Physiotherapy Clinic FOR THIS INJURY YES / NO** **If YES, how many treatments have you had? …………….**
DATE OF INJURY:		**BODY SITE(S) INJURED**

CAUSE OF INJURY:
Describe how the injury occurred

PLACE OF INJURY ie HOME / WORK		**If work injury, please advise Company Name, Address and Telephone No:**
LOCATION: ie CHRISTCHURCH		

Work Intensity: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Is this injury as a result of a motor vehicle accident? ☐ YES ☐ No

Is this a work related gradual process, disease or infection claim? ☐ YES ☐ No

CONSENT TO TREATMENT:

I hereby agree to consent to treatment by an appropriately qualified Physiotherapist for the purpose for providing comprehensive physiotherapy services as may be necessary in support of my illness, injury or condition. I have been given the opportunity to read clinic information prior to treatment. I understand I have the right to decline part or all of the treatment being offered. I understand my right to a second opinion. I consent to receive emails from this practice.

AGREEMENT TO PAY:

I understand that I am liable for payment:

- Of a co-payment of $32 ($26 Concession) per consultation. At Campus Health ONE initial ACC appointment per year is free and follow-ups treatments are $20.
- If any treatment is declined by ACC or other funder I am liable for the cost of a private appointment, $68 ($62 concession).
- For the costs of materials such as collars, splints and taping.
- For non-attendance or late cancellation of appointments. (a $25 fee will apply)

I understand that in the event of this Practice engaging a Debt Recovery Service to recover your debt, you will be liable for any recovery fees.

CONSENT TO RELEASE INFORMATION TO A THIRD PARTY

I consent to the disclosure of my records to any person/organization necessary for the effective management of my condition.
I consent to a discharge/update report being sent to my doctor or medical centre.

ACC DECLARATION

DECLARE: That the information I have given about this claim is true and correct and that I have not withheld any information likely to affect my application.
I AUTHORISE: The collection and release of any information about me to the extent that this is needed to prevent future injuries, determine cover and/or assess my entitlement to compensation, rehabilitation assistance, medical treatment and/or the appropriate level of care and personal attention that I should receive. ACC to contact anyone who holds relevant information, including any external agencies or service providers (such as medical practitioners, specialists, New Zealand Police, and Treatment Providers, IRD, WINZ, Assessment Agencies, employers and witnesses to the injury

SIGNED: *(If under 16 must be signed by parent/guardian)*	**DATED:**	***Please complete questions over the next page***

Outcome Measures

Client Name: **Date:**

Patient Specific Functional Scale:

Please identify **3** activities that you are having difficulty with due to your injury and circle a score out of 10 on your ability to complete them.

- 0 is unable to complete the activity at all.
- 10 is able to complete the activity at the same level as before you were injured.

Type of Activity: ……………………………………………

0 1 2 3 4 5 6 7 8 9 10

Unable to complete Able to complete

Type of Activity: ………………………………………………

0 1 2 3 4 5 6 7 8 9 10

Unable to complete Able to complete

Type of Activity: ………………………………………………

0 1 2 3 4 5 6 7 8 9 10

Unable to complete Able to complete

Numerical Pain Rating Scale:

Please circle your pain level on a scale of 0-10. This is the average over the last 24 hours.

Also circle with regards to your BEST and WORST pain level related to this injury – You should have circled three numbers

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

What is the main thing you would like to achieve by the end of **today's** session?________

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What is your main goal that you want to achieve with physiotherapy treatment?

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