IMPACT Clinical Summary Form

This form is to be used by GPs to report on each consultation remunerated under the IMPACT Program.

GP Details

GP Name

GP Practice Name

GP Program ID

Patient Details

QBE Claim No

Name

First Name

Last Name

Date of Birth

Gender

Male Female Not Specified

Consultation Details

(This is the reason for your patient presenting today.)

Date of this Consultation

Patient Consultation Type (Select all that apply)

Initial Assessment Pain Management Planning

Consultation Remuneration Eligibility Check

Patients must be:

- 18 years of age and over
- Covered by a QBE Workers Compensation policy
- have a current experience of pain
- be within 3 months of injury onset
- be at high-risk of an opioid prescription but not be dependent on opioid medication for consultations to be remunerated.

Please tick this box to confirm that the patient meets the eligibility criteria

Assessment of Patient

Check which domains are of concern for this patient, which domains you made a referral to another provider for, and which domains you have recommended patient active self-management for [check all that apply].

Harmful structural contribution

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Social Functioning

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Occupational Functioning

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Mood

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Anxiety

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Other Mental Health

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Physical Activity

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Nutrition

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Sleep

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Alcohol

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Cigarette Smoking

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Recreational Drug Use

- Of concern? (Tick if yes)
- Referral made or investigation ordered
- Active patient self-management discussed

Referrals

Please list the healthcare provider types you have referred the patient to (e.g. physiotherapy)

Prescriptions

Was an opioid prescribed for this patient in this consultation?

Yes No

Type

Dose

Have you established with the patient a maximum dose and timeframe for opioid use?

No, I have not established maximum dose or maximum timeframe Yes

Maximum Dose

Maximum Timeframe

Was another schedule 8 medication prescribed for this patient in this consultation?

Yes No

Type

Dose

Is the patient currently taking an opioid medication (that was not prescribed in this consultation)?

Yes No

Does the patient currently have a prescription for medicinal cannabis or cannabinoids?

Yes No

Have you checked TasScript for opioid prescriptions for this patient?

Yes No

If there are issues of opioid dependence with this patient, the consultations for this patient are not eligible for remuneration.
To check TasScript, please copy and paste the following URL into the web browser of your choice:
www.tasscript.health.tas.gov.au

Program Requests

Would you like to request a case consultation with the program's pain management specialist in relation to this patient?

Yes No

Would you like to request case coordination support for this patient?

If yes please also advise the patient of your request.

Yes No

If yes, please indicate which healthcare providers you would like our case coordinators to connect you with:

After each IMPACT consult with a Workers Comp, you should complete this form and email to hss.team@uhg.com