# Assessment Request

Once completed please email this form to Care-Requests@icare.nsw.gov.au and include the following in the subject header: Assessment Request [Person’s name and number] [Coordinator name]

### 1.1 Person’s details

|  |  |
| --- | --- |
| Name  | Participant number or claim number  |
|   |   |
| Address |
|   |
| Contact name | Contact Phone |
|   |   |
| Date of injury | Age |
| Click or tap to enter a date. |   |
| Injury |
| [ ]  TBI | [ ]  SCI Level: ASIA score:  | [ ]  Other (specify):  |

### 1.2 Assessment requested by

|  |  |
| --- | --- |
| Name  | Qualification  |
|   |   |
| Organisation | ABN |
|   |   |
| Work days / hours | Phone |
|   |   |
| Email |
|   |

### 1.3 Assessment provided by

|  |  |
| --- | --- |
| Name  | Qualification  |
|   |   |
| Organisation | ABN |
|   |   |
| Work days / hours | Phone |
|   |   |
| Email |
|   |

### 1.4 Status

|  |
| --- |
| [ ]  Interim - Date of end of interim participation period: Click or tap to enter a date.[ ]  Lifetime |

*For interim status, assessments cannot extend beyond the interim participation period*

### 1.5 Proposed assessment date

|  |  |
| --- | --- |
| Does the person have a current My Plan? | Proposed date for requested assessment*(should not extend beyond plan expiry date)* |
| [ ]  Yes – what is the expiry date? Click or tap to enter a date.[ ]  No | Click or tap to enter a date. |

### 1.6 Attachments

|  |
| --- |
| **Reports/documents attached?** *(Please list any reports of documents such as quotes included with this request)* |
| [ ]  Yes – Details: [ ]  No |

## 2. What is the person’s current status?

2.1 Current health conditions, impairments, activity limitations or participation restrictions relevant to this request (*include any non-injury related health concerns or impairments*)

|  |
| --- |
|   |

### 2.2 Current services received or approved

|  |
| --- |
|   |

### 2.3 Pre-injury information relevant to this request

|  |
| --- |
|   |

## 3. Requested assessment

### 3.1 Provide justification for your request

|  |
| --- |
|   |

## 4. Service provider declaration

The person has been involved as much as possible in the development of this request in collaboration with their family member or nominated person if necessary. The person (and family member or nomination person) agrees with the this request.

|  |  |
| --- | --- |
| Name  | Date  |
|   | Click or tap to enter a date. |

## 5. Request for approval

List the requested **assessment** services, service providers, payment codes, hours and costs (including GST) including non-direct services such as provider travel.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | Provider name, Organisation (*Billing as*), Address, ABN details & PhoneSIRA/HIC Approval No. (*where applicable*) | Code | Hours | Cost(incl. GST) |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
| **Total cost:** | $  |

|  |  |
| --- | --- |
|  | **icare**GPO Box 4052, Sydney NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |