

# Assessment Report and Treatment Plan (ARTP)

Complete this form to request prior approval from ACC for elective surgery services. Return this form to us either by email to [ARTPS4ESU@acc.co.nz](mailto:ARTPS4ESU@acc.co.nz) or via HealthLink mailbox (ACCEARTP).

To avoid unnecessary delays for the patient, please complete all the mandatory fields (\*). We need full and accurate information to make a prompt and informed decision.

Please do not submit this ARTP to ACC if: the surgery request is a prerequisite to access medical insurance AND you believe there is no causal link between the accident event and the specific clinical diagnosis requiring treatment.

## 1. Kiritaki (Client) and claim details

\* Claim number:

\* Date of injury:

\* Full name:

\* NHI number:

\* Address:

\* Date of birth:

\* Primary contact number:

Email (optional):

Alternate contact number (optional):

\* Referring provider:

\* Date of referral from provider:

\* General practitioner:

## 2. Diagnosis, history, and examination

Attach any relevant medical records to this submission, e.g. diagnostic tests/imaging, GP/Physio referral letter, lodgement notes.

\* Specific clinical diagnosis requiring treatment:  
Please specify a code for the diagnosis if available, e.g. READ, ICD-10, SNOMED

\* In your clinical opinion, did the accident event cause the diagnosis/injury requiring the proposed treatment? (Yes/Unclear)?

\* Please describe all the relevant factors that support a causal link between the accident event and the diagnosis/injury requiring the proposed treatment. See 'consideration factors' on the [ACC website](#). Consider factors

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<p>such as:</p> <ul style="list-style-type: none"> <li>• Initial presentation</li> <li>• Mechanism of injury</li> <li>• Clinical examination findings</li> <li>• Diagnostic tests/radiology</li> </ul>	
<p>* History of the current condition - include the mechanism of injury:</p>	
<p>* Clinical examination findings:</p>	
<p>* Diagnostic tests and imaging:</p>	
<p>* Pre-existing factors, e.g. relevant medical history, prior surgery/ACC claims, medication etc:</p>	
<p><b>3. Proposed management and prognosis</b></p>	
<p>* Prognosis (expected timeframe for the client to recover):</p>	
<p>Estimated return to work (if applicable):</p> <p>Include details on:</p> <ul style="list-style-type: none"> <li>• Full return to work/fit-for-selected work</li> <li>• Return to work program/pathway</li> </ul>	
<p>* Expected post-operative instructions:</p> <p>Include details on:</p> <ul style="list-style-type: none"> <li>• Rehabilitation protocol</li> <li>• Weightbearing status</li> <li>• Functional limitations</li> <li>• Precautions</li> </ul>	
<p>* Is the client likely to need support before or after surgery? (Yes/No)?</p>	
<p><b>If yes</b>, specify, e.g. physiotherapy, vocational rehabilitation, weekly compensation, home</p>	

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help, transport, equipment, childcare:

## 4. Treatment details

\* Recommended surgical treatment:

\* Body site to be treated:

\* Body side (Left/Right/Both/Not applicable):

\* ACC procedure code and description (1):

**If non-core**, describe proposed procedure and additional details where required, e.g. rationale for second surgeon, details of implants, use of unusual or unique supplies, unusually complex needs or supports.

ACC procedure code and description (2):

\* Clinical priority:

- H1 – clinically urgent
- H2 – home help required
- H3 – receiving weekly compensation
- H4 – risk of losing employment
- Routine

**If H1 - H4**, describe the rationale:

Proposed surgery date:

Length of operation:

Length of stay required:

## 5. Certification and specialist details

I certify that, on the date shown, I have personally examined and/or treated this patient. I have discussed the treatment options with them and advised why the recommendation is the appropriate treatment in this case. The patient, or their representative, has authorised me to provide this information to ACC on their behalf.

\* Provider ID:

\* Specialist name:

\* Practice:

\* Phone:

\* Email:

\* Specialist signature:

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\* Date signed:

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## 6. Lead supplier details

\* Lead supplier:

\* Facility:

\* Contract number:

Contracted  Non-contracted (surgery under regulations)

\* Vendor ID:

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In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.