

# Application for additional allied, therapeutic and psychology cover 2021

Executive, Comprehensive and Priority Plans only

## Who we are

Discovery Health Medical Scheme, registration number 1125, is a not-for-profit organisation registered with the Council for Medical Schemes (CMS), and is the medical scheme that you are a member of.

Discovery Health (Pty) Ltd, registration number 1997/013480/07, is a separate company and an authorised financial services provider and is the administrator and managed care organisation for Discovery Health Medical Scheme and takes care of the administration of your membership.

## Contact us

Tel (members): 0860 99 88 77, Tel (health partners): 0860 44 55 66, [www.discovery.co.za](http://www.discovery.co.za), PO Box 784262, Sandton, 2146,  
1 Discovery Place, Sandton, 2196.

## Purpose of the form

This application form is for members on the Executive, Comprehensive and Priority Plan to apply for additional cover for allied, therapeutic and psychology healthcare services above the annual benefit limit for conditions that do not form part of the Allied, Therapeutic and Psychology Extender Benefit. Make reference to the footnote that indicates the expiry date of the form. Download the latest version of all forms from [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Manage your health plan > Find important documents and certificates.

## What you must do

- All relevant sections must be physically signed by the patient and cannot be signed digitally. The patient must sign and date any changes.
- Member must complete section 1 and section 2.
- Sign section 1 of the application form.
- Read "Important information" section on page 2.
- Take the application form to your healthcare professional to complete the relevant sections.
- Email the completed form to [ATmotivations@discovery.co.za](mailto:ATmotivations@discovery.co.za), or post it to Discovery Health Medical Scheme, PO Box 784262, Sandton 2146.
- Refer to relevant benefit guide for complete information. Up to date forms are available on [www.discovery.co.za](http://www.discovery.co.za) under Medical Aid > Manage your health plan > Find important documents and certificates.

## 1. Patient information (to be completed by the patient)

Title	<input type="text"/>	Surname	<input type="text"/>
First name(s)	<input type="text"/>		
Gender	<input type="checkbox"/> M <input type="checkbox"/> F	Identity number	<input type="text"/>
Member number	<input type="text"/>		
Telephone (H)	<input type="text"/> - <input type="text"/>	Telephone (W)	<input type="text"/> - <input type="text"/>
Cellphone	<input type="text"/>		
Email	<input type="text"/>		

Signature of patient (if patient is a minor, main member or guardian to sign)

Date  -  -



I acknowledge that I have read and understood the conditions for additional benefits under "Important information"

(Section 3), on page 2.

## 2. Details of healthcare professionals (to be completed by healthcare professional/s)

2.1. List all healthcare professionals not included in the application form (for example: GPs, specialists, other allied, therapeutic and psychology professionals)

Name	Discipline
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>


2.2. Current medicine the patient is on, relevant to the primary diagnosis


**3. Important information**

I give permission for my healthcare professional to provide Discovery Health Medical Scheme and Discovery Health (Pty) Ltd (as administrator) with my diagnosis and other relevant clinical information required to review my application for additional allied, therapeutic and psychology benefits.

I understand that:

- 3.1. Funding for additional allied, therapeutic and psychology services is subject to meeting benefit entry requirements as determined by Discovery Health Medical Scheme.
- 3.2. Funding for additional allied, therapeutic and psychology services will only be effective once I have reached the annual Allied and Therapeutic Benefit limit applicable on my plan type.
- 3.3. The outcome of the decision will be sent via email to the member's email address as listed on our records.
- 3.4. Only services from biokineticists, chiropractors, occupational therapists, physiotherapists, psychologists, social workers (in mental health) and speech and hearing therapists (speech-language therapists and audiologists) will be considered for funding.
- 3.5. Discovery Health Medical Scheme will pay the claims for the approved additional allied, therapeutic and psychology services from the available funds in my Medical Savings Account according to the payment option I selected. Once I reached the Above Threshold Benefit, all of the approved allied, therapeutic and psychology claims will pay at 100% of the Discovery Health Rate.
- 3.6. For Priority Plans, these claims will be subject to the Above Threshold Benefit limit.
- 3.7. Members on the Classic Smart Comprehensive plan, need to reach the Annual Threshold to have cover for day-to-day medical expenses.
- 3.8. Funding for additional healthcare services will be effective from when Discovery Health Medical Scheme receives a completed, signed form.
- 3.9. The approved additional allied, therapeutic and psychology benefits only applies for the dependant whose date of birth is on the application form.
- 3.10. I may need to send an updated or new application form, if required by Discovery Health Medical Scheme or its advisory panels (representatives from the relevant professional body).
- 3.11. Consent for processing my personal information, as per privacy Statement:
  - 3.11.1. I give the Scheme and the administrator consent to have access to and process all information (including general, personal, medical or clinical information) that is relevant to this application.
  - 3.11.2. I understand that this information will be used for the purposes of applying for and assessing my funding request for additional allied, therapeutic and psychology services.
  - 3.11.3. I give permission to the Scheme and the administrator to share my medical and clinical information with the external advisory panel, should they need it.
  - 3.11.4. I consent to the Scheme and the administrator disclosing, from time to time, information supplied to them (including general, personal, medical or clinical information) to my healthcare provider, to administer the additional allied, therapeutic and psychology benefits.

**4. Notes to healthcare professional**

- 4.1. The healthcare professional's fee for completion of this form will be reimbursed as per their relevant report writing billing code and/or billing guidelines, on submission of a separate claim. Payment of the claim is from the day-to-day benefits (if applicable to the member's plan type), subject to Discovery Health Medical Scheme rules and availability of funds and where the member is a valid and active member at the service date of the claim.
- 4.2. In line with legislative requirements, please ensure that when using your report writing billing code, you submit the ICD-10 diagnosis code(s). As per industry standards, the appropriate ICD-10 code(s) to use for this purpose would be those reflective of the actual condition(s) for which the form was completed. If funding for multiple conditions is applied for, then it would be appropriate to list all the relevant ICD-10 codes.
- 4.3. I understand that panel members from the relevant advisory panel (representatives from the relevant professional body) will review the information I provide by completing this form as well as the motivation I attach. This information will form part of the final recommendation

and funding decision as communicated to the patient on the completion of this application process.

- 4.4. We will not consider cover for both a chiropractor and physiotherapist for the same condition.
- 4.5. We will not consider cover for both a psychologist and a social worker for the same condition.
- 4.6. As a healthcare funder, Discovery Health Medical Scheme funds treatments related to medical or clinical needs. When a medical scheme member applies for funding for additional allied, therapeutic and psychology benefits after they reached their annual family limit for the year, it is important to note that the additional benefit does not include therapies related to disorders of a scholastic nature (educational), including but not limited to school readiness testing. The additional benefit for allied, therapeutic and psychology services is not designed to fund any conditions of a non-clinical or non-medical nature. If the therapy is clinically indicated, we will require supporting information for current or retrospective review.
- 4.7. Certain assessments are not considered for funding through this application process, they are funded from day-to-day benefits subject to the annual family Allied, Therapeutic and Psychology Benefit limit.
- 4.8. Funding for additional healthcare services will only commence from when Discovery Health Medical Scheme receives a completed, signed form. Failure to complete all relevant information under each section of this form can result in the application being sent back for further information, in order to ensure that the review process can take place

## 5. Biokineticist section

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age  Patient date of birth  -  -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional  Date  -  -

### 5.1. Information about the patient's condition

#### 5.1.1. Diagnosis details of current diagnosis

Please specify detailed ICD code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

5.1.2 . If your patient has a spine-related condition, please complete and attach the relevant biokinetic spinal evaluation form which can be found on the Healthcare Professional Zone at [www.discovery.co.za](http://www.discovery.co.za)

Condition	
Cervical spine	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lumbar spine	<input type="checkbox"/> Yes <input type="checkbox"/> No

### 5.2. Information about the present treatment required referring to the above ICD-10 code

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis treatment


Attach description to show what phase the member is currently in.

5.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2014		<input type="checkbox"/> Yes <input type="checkbox"/> No
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start of therapy   -   -

Start date of therapy in current year   -   -

Last date of therapy in current year   -   -

Total number of sessions and frequency in current year:

5.2.2. Description of past treatment sessions to date, of above mentioned ICD 10 code (Please also indicate the procedure codes used)


5.2.3. Motivation for treatment for above mentioned ICD 10 code (Include impact of treatment to date on functionality)


5.2.4. Goals for further treatment sessions


5.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)


**6. Chiropractor section**

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age  Patient date of birth  -  -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional  Date

6.1. Information about the patient's condition

6.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

6.2. Information about the present treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

Attach description to show what phase the member is currently in.

6.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy

D	D	-	M	M	-	Y	Y	Y	Y
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Start date of therapy in current year

D	D	-	M	M	-	Y	Y	Y	Y
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Last date of therapy in current year

D	D	-	M	M	-	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Total number of sessions and frequency in current year:

6.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)


6.2.3. Motivation for treatment (Include impact of treatment to date on functionality)


6.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)


6.2.5. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis)


**7. Occupational therapist section**

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age  Patient date of birth  -  -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional  Date

7.1. Information about the patient's condition

7.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

7.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current treatment

7.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy   -   -

Start date of therapy in current year   -   -

Last date of therapy in current year   -   -

Total number of sessions and frequency in current year:

7.3. Brief summary of occupational therapy to date (Please also indicate the procedure codes used)




7.4. Motivation for treatment (Include impact of treatment to date on functionality)


7.5. Detailed goals for further therapy


7.6. Brief history of patient's pre-morbid functioning and relevant patient history


**7.7. Motivation for treatment of adults – Please include additional motivation with this application including:**

Information about assistance required for participation in activities of daily living, functional transfers and upper limb function, cognitive and/or perceptual function, and pre-morbid work/school/university history.

**Please note: Standardised tests and scores should be indicated in reports when formal testing was included in the assessment.**

**7.8. Motivation for treatment of children – Please include additional motivation with this application including:**

Information about impact on development, behaviour, school and social functioning, as well as relevant birth and background history.

Please note: Standard scores should be indicated in reports when formal testing was included in the assessment.

**Please include additional assessment and progress reports with this application for paediatric cases.**

**8. Physiotherapist section**

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age

Patient date of birth   -   -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional

Date

8.1. Information about the patient's condition

8.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

8.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current treatment

**Attach description to show what phase the member is currently in.**

8.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy

Start date of therapy in current year

Last date of therapy in current year 

D	D
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 - 

M	M
---	---

 - 

Y	Y	Y	Y
---	---	---	---

Total number of sessions and frequency in current year:

8.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)


8.2.3. Motivation for treatment (Include outcome measures used and scores/impact of treatment to date on functionality)


8.2.4. Goals for further treatment sessions


8.2.5. Relevant patient history (include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, birth history, milestones and history of primary diagnosis.)


**9. Psychologist section**

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number 

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Patient age

Patient date of birth 

D	D
---	---

 - 

M	M
---	---

 - 

Y	Y	Y	Y
---	---	---	---

Healthcare professional name and surname

Tick the relevant box: Are you a  Clinical psychologist  Counselling psychologist  Educational psychologist

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Cellphone  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional

Date

9.1 Information about the patient's condition

9.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

9.1.2. Multi-axial diagnosis: Please give a DSM-V diagnosis

Current GAF and/or GARF	DSM-V
Pre-treatment GAF and/or GARF	

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning (If a paediatric assessment has been done, please include/attach report recommendations):


9.1.3. Relevant patient history (Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis.) Please also indicate the procedure codes used.

9.1.3.1. Previous diagnosis


9.1.3.2. Current symptom presentations


9.1.3.3. Occupational and social functioning


9.1.3.4. Previous treatment


9.1.3.5. Hospitalisation


9.1.3.6. History of primary diagnosis (including a description of stressors for trauma and stressor-related disorders)


9.1.4. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy

Start date of therapy in current year

DD - MM - YYYY

Last date of therapy in current year

DD - MM - YYYY

Total number of sessions and frequency in current year: \_\_\_\_\_

9.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

9.2.1. Indicate method(s) of treatment and treatment to date

\_\_\_\_\_

9.2.2. Treatment to date including additional sessions in the past three years (Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)

\_\_\_\_\_

9.2.3. Motivation for additional treatment

\_\_\_\_\_

9.2.4. If you are treating multiple members of the same family, please motivate and give clear reasons, as this might pose an ethical consideration

\_\_\_\_\_

## 10. Social Worker (additional mental healthcare benefits)

Confirm that you are a member of the Discovery Health Social Worker in Mental Health Network, before completing the below section. **Please note:** Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age  Patient date of birth  -  -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.

Signature of healthcare professional

Date  -  -

### 10.1. Information about the patient's condition

#### 10.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			< 12 weeks	> 12 weeks

#### 10.1.2. Multi-axial diagnosis: Please give a DSM-V diagnosis

Current GAF and/or GARF	DSM-V
Pre-treatment GAF and/or GARF	

Additional/supporting comments about diagnosis, including impact on social and occupational/scholastic functioning:

  
  
  
  


#### 10.1.3. Relevant patient history

(Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation, history of primary diagnosis) Please also indicate the procedure codes used.

10.1.4. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy   -   -

Start date of therapy in current year   -   -

Last date of therapy in current year   -   -

Total number of sessions and frequency in current year:

10.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

10.2.1. Indicate method(s) of treatment and treatment to date


10.2.2. Treatment to date including additional sessions in the past three years

(Indicate impact of treatment to date on social and occupational functioning. For children, include information about impact on development, behaviour, school and social functioning.)




10.2.3. Motivation for additional treatment


**11. Speech-language therapist and audiologist section**

**Please note:** This section is only to be completed by the treating healthcare provider. If not, the form won't be accepted. Due to confidentiality, the patient's name is excluded, but please make sure that you include the patient's date of birth.

Membership number

Patient age  Patient date of birth   -   -

Healthcare professional name and surname

BHF practice number

Special interest

Telephone (W)  -  Fax  -

Email

**I acknowledge that I have read and understood the conditions for additional benefits as mentioned in section 4 on page 2.**

Signature of healthcare professional

Date

This application should be supported by a comprehensive report.

11.1. Information about the patient's condition

11.1.1. Diagnosis details

Please specify detailed ICD-10 code(s)	Description	Date and nature of incident / onset	Duration	
			<b>&lt; 12 weeks</b>	<b>&gt; 12 weeks</b>

11.2. Information about the treatment required

Consultation or procedure code(s)	Length of sessions (minutes)	Number of treatments required per week or month	Number of total sessions required for the remainder of the current benefit year to complete current diagnosis

11.2.1. Number of sessions used

Year	Total amount of sessions (excluding additional benefit sessions that were approved)	Applied for additional benefit
2015		<input type="checkbox"/> Yes <input type="checkbox"/> No
2016		<input type="checkbox"/> Yes <input type="checkbox"/> No
2017		<input type="checkbox"/> Yes <input type="checkbox"/> No
2018		<input type="checkbox"/> Yes <input type="checkbox"/> No
2019		<input type="checkbox"/> Yes <input type="checkbox"/> No
2020		<input type="checkbox"/> Yes <input type="checkbox"/> No
2021		<input type="checkbox"/> Yes <input type="checkbox"/> No

Amount of additional funding sessions awarded in the previous benefit year:

Original start date of therapy   -   -

Start date of therapy in current year   -   -

Last date of therapy in current year   -   -

Total number of sessions and frequency in current year:

11.2.2. Description of past treatment sessions to date (Please also indicate the procedure codes used)


11.2.3. Motivation for treatment

(Indicate impact of treatment to date on functionality)


11.2.4. Goals of further treatment sessions


11.2.5. Relevant patient history

(Include previous diagnoses, occupational and social functioning, previous treatment, hospitalisation etc.

For children please include the child's birth history, milestones and history of primary diagnosis)

Please include additional assessment and progress reports to this application for paediatric cases
