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ARTP E-Form Specification Document

Patient Management System Update for ARTP E-Form

This document outlines the specifications required for updating the ARTP e-form in your Patient Management System. The following tables detail the fields, their requirements, and how each section of the form should be displayed.

1. Client and Claim Details

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Claim Number | Unique identifier for the claim | Text | Yes |
| Date of Accident | Date when the accident occurred | Date (dd/mm/yyyy) | Yes |
| Full Name | Patient's full name | Text | Yes |
| NHI Number | National Health Index number | Text | Yes |
| Address | Patient's address | Text | Yes |
| Date of Birth | Patient's date of birth | Date (dd/mm/yyyy) | Yes |
| Primary Contact Number | Main contact number for the patient | Text | Yes |
| Email | Patient's email address | Email | No |
| Alternate Contact Number | Secondary contact number for the patient | Text | No |
| Referring Provider | Name of the referring provider | Text | Yes |
| Date of Referral from Provider | Date when the referral was made | Date (dd/mm/yyyy) | Yes |
| General Practitioner | Name of the patient's general practitioner | Text | Yes |

1. Diagnosis, History and Examination

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Specific Clinical Diagnosis Requiring Treatment | Diagnosis code if available (e.g. READ, ICD-10, SNOMED) | Text | Yes |
| Accident-Related Diagnosis | Whether the accident event caused the diagnosis/injury (YES/UNCLEAR) | Dropdown | Yes |
| Relevant Factors Supporting Causal Link | Details supporting the causal link between the accident and the injury | Text | Yes |
| History of Current Condition | Description of the condition's history, including the mechanism of injury | Text | Yes |
| Clinical Examination Findings | Findings from the clinical examination | Text | Yes |
| Diagnostic Tests and Imaging | Details of any diagnostic tests and imaging conducted | Text | Yes |
| Pre-Existing Factors | Relevant medical history, prior surgeries/ACC claims, medications | Text | Yes |

1. Proposed Management & Prognosis

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Prognosis | Expected timeframe for the client's recovery | Text | Yes |
| Estimated Return to Work | Details on return to work/fit-for-selected work and return to work program/pathway | Text | No |
| Expected Post-Operative Instructions | Details on rehabilitation protocol, weightbearing status, functional limitations, and precautions | Text | Yes |
| Need for Support Before/After Surgery | Whether the client is likely to need support before or after surgery (YES/NO) | Dropdown | Yes |
| If YES, Specify Support | Details on required support (e.g., Physiotherapy, Vocational Rehabilitation, Weekly Compensation, Home Help, Transport, Equipment, Childcare) | Text | No |

1. Treatment Details

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Recommended Surgical Treatment | Details of the recommended surgical treatment | Text | Yes |
| Body Site to Be Treated | Specific site on the body to be treated | Text | Yes |
| Body Side | Side of the body to be treated (Left/Right/Both/Not applicable) | Dropdown | Yes |
| ACC Procedure Code and Description (1) | Procedure code and description (If non-core, provide details on the proposed procedure, length of stay, second surgeon, theatre time) | Text | Yes |
| ACC Procedure Code and Description (2) | Additional procedure code and description if applicable | Text | No |
| Clinical Priority | Clinical priority of the procedure (H1 – H4, Routine) | Dropdown | Yes |
| Rationale for Priority (if H1 – H4) | Rationale for the chosen clinical priority | Text | No |
| Proposed Surgery Date | Planned date for the surgery | Date | No |
| Length of Operation | Expected duration of the surgery | Text | No |
| Length of Stay Required | Expected length of stay in the facility after the surgery | Text | No |

1. Certification & Specialist Details

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Provider ID | Unique identifier for the provider | Text | Yes |
| Specialist Name | Name of the specialist | Text | Yes |
| Practice | Name of the specialist's practice | Text | Yes |
| Phone | Contact number for the specialist | Text | Yes |
| Email | Email address of the specialist | Email | Yes |
| Specialist Signature | Signature of the specialist | Signature | Yes |
| Date Signed | Date when the form was signed by the specialist | Date | Yes |

1. Lead Supplier Details

|  |  |  |  |
| --- | --- | --- | --- |
| Field | Description | Type | Mandatory |
| Lead Supplier | Name of the lead supplier | Text | Yes |
| Facility | Name of the facility where the surgery will be performed | Text | Yes |
| Contract Number | Contract number for the surgery | Text | Yes |
| Contract Status | Whether the surgery is contracted or non-contracted | Checkbox | Yes |
| Vendor ID | Identifier for the vendor | Text | Yes |

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.