Outcome Measures

Please complete the PSFS and NPRS, or other outcome measures

Section 1 - Client Details

ACC45 number or claim number: [redacted] **Date of Birth:** [redacted]

Client Name: [redacted] [redacted]
Surname First Names

Section 2 - Evaluation

NB: If the client is off work, 1 activity must relate to return to work.

A) Initial Assessment
PSFS: "I am going to ask you to identify three to five important activities that you are unable to do or are having difficulty with as a result of your problem." (Clinician: show scale to patient and have the patient rate each activity).

B) Follow-up Assessments
PSFS: "When I assessed you on (state previous assessment date), you told me that you had difficulty with (read all activities from list). Today, do you still have difficulty with: (read and have patient score each item in the list one at a time)?"

C) PSFS scoring scheme (Point to one number):

0 1 2 3 4 5 6 7 8 9 **10**

Unable to perform activity — *Able to perform perform activity at the same level as before injury or problem*

ACC Permission to use the PSFS authorised by Paul Stratford, December 2009.

Initial Visit 22/02/2021

Activity *(Please refer to the guidelines for correct workding of PSFS.)*	**Rate Performance ability from 0-10**
full painfree arom neck	3
full shift at work painfree	5
Average Score	**4.0**

Numeric Pain Rating Scale (NPRS)

Rate your client's pain on a scale of 0 to 10, where 0 equals no pain and 10 equals the worst imaginable pain (or worst possible pain). Please rate their average pain in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 **10**

No Pain — *Worst Pain Possible*

Initial Visit 22/02/2021

Rate pain from 0-10 3

Other outcome measures if applicable

eg. Oswestry 60%, VISA-A 54/100, LBP Disability Questionnaire, DASH, Neck Disability Index or Lysholm Knee Scoring Scale

Initial Visit 22/02/2021

Outcome Measure Name

Section 3 - Patient Declaration

I declare that the information (including personal details) on this form is true and correct.

Patient Signature: _____ **Date:** 22/02/2021

[redacted]

Section 3 - Provider Details, certificate, signature and treatment start date

Name of treating practioner: [redacted]

ACC provider number: [redacted]

ACC vendor number: [redacted]

This treatment is for the personal injury for which the client has cover and
I have discussed the treatment options with the client and advised why the recommendation is the appropriate treatment in this case.

Provider's Signature: _____ **Date:** 22/02/2021

Send the original completed form to ACC with your initial assessment, relevant clinical notes and ACC32

The information collected on this form will only be used to fulfil the requirements of the Injury Prevention, Rehabilitation and Compensation Act 2001. In the collection, use and storage of information, ACC will at all times comply with the obligations of the Privacy Act 1993 and the Official Information Act 1982.