

## REFERRAL FOR OCCUPATIONAL REHABILITATION SERVICES

<b>Worker's Surname</b>		<b>Injury Details</b>	
First Name:		Date of Injury:	
Address: Email:		Type of injury:	
Phone:		Occupation:	
DOB:		Claim Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Interpreter:	<input type="checkbox"/> Yes <input type="checkbox"/> No Language:	Selected duties:	
Status:	<input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> CAS <input type="checkbox"/> At work <input type="checkbox"/> Off work		Ceased: <input type="checkbox"/> Terminated Date:

<b>Employer</b>		<b>Insurance Company</b>	
Employed By:		Insurer:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	
RTW Coord:		Contact:	
Supervisor	Ph:	Liability Status:	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Unknown

<b>Reason for Referral: (tick one or more)</b>		<b>Treating Doctor:</b>	
<input type="checkbox"/> Case Management	<input type="checkbox"/> ADL Assessment	Name:	
<input type="checkbox"/> Initial Assessment	<input type="checkbox"/> Job Seeking	Address:	
<input type="checkbox"/> Workplace Assessment	<input type="checkbox"/> Psychological Assessment	Phone:	
<input type="checkbox"/> Functional Assessment	<input type="checkbox"/> Psychological Counselling	Fax:	
<input type="checkbox"/> Functional Education	<input type="checkbox"/> Rehabilitation Counselling	Email:	
<input type="checkbox"/> Aids & Equipment	<input type="checkbox"/> Vocational Assessment	Physio name:	
	Insurer to send IMP's please Employer to send WCMC, SD plan etc	Ph: Email:	
		<b>Specialist:</b>	
		Ph:	

**Insurer approval for Injury Management Services:** Approval is hereby given to undertake an initial rehab assessment up to the development of a plan or as otherwise specified (S63A). Anyone can make recommendations for occupational rehabilitation referral however Insurer is required to make referral / sign referral form to be able to claim GST and authorize payment of provider invoices as per WorkCover guidelines.

Referrer:	Employee Signed	Date:	
Referrer:	Insurer Signed	Date:	