Accelerate
INJURY MANAGEMENT | DISPOSABLE CONSUMABLES
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ABN 60 082 683 663
Supply Nation CERTIFIED

REFERRAL FOR OCCUPATIONAL REHABILITATION SERVICES

Worker's Surname		*Injury Details*	
First Name:		Date of Injury:	
Address: Email:		Type of injury:	
Phone:		Occupation:	
DOB:		Claim Number:	☐Yes ☐No ☐Unknown
Interpreter:	☐Yes ☐No Language:	Selected duties:	
Status:	☐FT ☐PT ☐CAS ☐At work ☐Off work Ceased:		☐Terminated Date:

Employer		*Insurance Company*	
Employed By:		Insurer:	
Address:		Address:	
Phone:		Phone:	
Fax:		Fax:	
Email:		Email:	
RTW Coord:		Contact:	
Supervisor	Ph:	Liability Status:	☐Accepted ☐Denied ☐Unknown

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