|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Worker’s Name: |  | | Claim No: | |  |
| Address: |  | | | | |
| Telephone: | h: | m: | | w: | |
| Date of Birth: |  | | Date of Injury: |  | |
| Diagnosis / Injury: |  | | | | |
| Occupation: |  | | Referral Date: |  | |

Referral Form

IW/Claimant Details

Reason for Referral (please tick)

|  |  |
| --- | --- |
| Initial assessment | Ergonomic Assessment |
| Workplace assessment | RTW/Case Management |
| Functional Capacity Assessment | Driver Rehabilitation/Training |
| Vocational Assessment | ADL Assessment |
| Business Mentoring | Employability Assessment |
| Job Seeking Services | Other |

Employer Details

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Company: |  | | | Contact |  | |
| Address: |  | | | | Email: |  |
| Telephone: |  | Mobile: |  | | Fax: |  |

Treating Doctors

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clinic |  | | | Contact |  | |
| Address: |  | | | | Email: |  |
| Telephone: |  | Fax: |  | | Role: | General Practitioner |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clinic |  | | | Contact |  | |
| Address: |  | | | | Email: |  |
| Telephone: |  | Fax: |  | | Role: |  |

Treating Physiotherapist/Other

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Clinic |  | | | Contact |  | |
| Address: |  | | | | Email: |  |
| Telephone: |  | Fax: |  | | Role: |  |

Referrer Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Company: |  | | | |
| Address: |  | | Telephone: |  |
| Contact: |  | Email: |  | |

Insurer Details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Company: |  | | | |
| Address: |  | | Telephone: |  |
| Contact: |  | Email: |  | |

Other Information

|  |  |  |  |
| --- | --- | --- | --- |
| Other Information: |  | | |
| Attachments: |  | | |
| Referred by: |  | Date: |  |
| Signature: |  | | |

Referral Procedures

1. Complete this form and email to: [referrals@workcom.com.au](mailto:referrals@workcom.com.au) or fax on 1300 654 426
2. Send latest medical information with the completed referral form.