|  |  |  |  |
| --- | --- | --- | --- |
| 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 or fax on 1300 654 426
2. Send latest medical information with the completed referral form.