Parramatta
Tel:(02) 9749 7666
Fax: (02) 9897 2488
email: admin@workershealth.com.au
Newcastle
Tel:(02) 4926 2129
Fax: (02) 4929 1960
email: newcadmin@workershealth.com.au

REHABILITATION REFERRAL FORM

CLIENT DETAILS				INJURY DETAILS	
Title:	Mrs			**Date of Injury:**	
Surname:				**Cause of Injury:**	
First Name(s):				**Type of Injury(s):**	
Date of Birth:		**Age:**		**UNION**	
Address Line 1:				**Union:**	
Address Line 2:				**Contact Name:**	
Suburb:		**Postcode:**		**Phone:**	
Home Phone:		**Mobile:**		**Mobile:**	
Interpreter Required:	No	**If yes language?**		**Email:**	
Occupation:				**NOMINATED TREATING DOCTOR**	
Email:				**Doctor's Name:**	
EMPLOYER DETAILS (At time of injury)				**Address Line 1:**	
Company Name:				**Address Line 2:**	
Contact Name:				**Suburb:**	**Postcode:**
Address:				**Phone:**	**Fax:**
Suburb:		**Postcode:**		**Mobile:**	
Phone:		**Mobile:**		**Email:**	
Email:				**INSURER DETAILS**	
Are you still employed?	No			**Insurer:**	
REASON FOR REFERRAL				**Claim No:**	
_____				**Case Manager:**	
_____				**Address:**	
I, _____ *(print name)*				**Suburb:**	**Postcode:**
wish to nominate the Workers Health Centre as my nominated rehabilitation provider to provide ongoing case management / return to work services: I provide informed consent for WHC to liaise with the agent, nominating treating Doctor (NTD), employer, treating professionals & independent review office (IRO).				**Phone:**	
				Mobile:	
				Case Manager email:	
Signature:					

How did you hear about us? Please provide a name			
Referred by the union ☐		Referred by my doctor ☐	
Referred by insurer ☐		Suggested by a colleague ☐	
Referred by my employer ☐		Researched you on my own ☐	
Referred by my lawyer ☐		Other ☐	

INSURER USE ONLY: Approval for Injury Management Services

Workers Health Centre requests approval for the following services:

Liability accepted: Yes ☐ No ☐ Single Rehabilitation Service/s ☐ Details: ADL Assessment

New Employer Services ☐ Same Employer Services ☐

Approval is hereby given for the above marked occupational rehabilitation services and a copy of the current Injury Management Plan (IMP) for this Injured Worker will be forwarded. An initial estimate of $3000 is placed on the file with insurer approval. When exhausted cost requests are submitted for further approval.

Signature: Employer / Insurer: Date:

Complete & **return** via **fax** to **02 9897 2488** *or* **email** admin@workershealth.com.au
Alternatively **post** *or* **drop off** to **Level 4, Suite 3, 20 - 24 Wentworth Street, Parramatta NSW 2150.**