Referral Form

rehab co
THE REHABILITATION COMPANY

Client

Name ..... Date of Birth .....

Address .....

Email ..... Phone .....

Client Injury

Injury .....

Date of Injury ..... Claim Number .....

At Work: ☐ Yes ☐ No Occupation .....

Pre-injury average wage ..... Pre-injury average hours .....

Employer

RTW Coordinator ..... Phone .....

Company ..... Email .....

Address .....

Doctor

Doctor ..... Phone .....

Address ..... Email .....

Medical Reports/Certificates attached: ☐ Yes ☐ No (Attach to email)

Agent / Party Responsible For The Payment Of Accounts

Contact ..... Phone .....

Company ..... Email .....

Address .....

Liability Accepted: ☐ Yes ☐ No

Service Required

- ☐ Workplace Rehabilitation Services up to the development of a Return to Work Plan
- ☐ Workplace Assessment
- ☐ Vocational Assessment (For suitable employment)
- ☐ Earning Capacity Assessment
- ☐ Functional Capacity Assessment
- ☐ Workplace Based Functional Capacity Assesment
- ☐ Ergonomic/Workstation Assessment
- ☐ Labour Market Analysis
- ☐ Job Seeking Skills Programme
- ☐ Targeted Assistance for Work Capacity Decisions
- ☐ Initial Assessment or NTD Case Conference
- ☐ Activities of Daily Living Assessment
- ☐ Home Assessment
- ☐ Driving Assessment
- ☐ Exercise Physiology Services
- ☐ Work Conditioning
- ☐ Psychological Counselling Services
- ☐ Bullying or Harassment Intervention
- ☐ Mediation and Conflict Resolution
- ☐ Medico Legal Assessment
- ☐ Pre-employment Functional Assessment
- ☐ Employer Education Services
- ☐ OHS Services
- ☐ Other .....

Name ..... Signature ..... Date .....