**Granville**
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

WORKERS HEALTH CENTRE
People I Recovery I Work

# REHABILITATION REFERRAL FORM

| CLIENT DETAILS | | | | INJURY DETAILS | | | |
|---|---|---|---|---|---|---|---|
| **Title:** | Prof/Dr/Mr/Ms/Miss/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:** | | **Fax:** | |
| **Home Phone:** | | **Mobile:** | | **Mobile:** | | | |
| **Interpreter Required:** | Yes/No | **If yes language?** | | **Email:** | | | |
| **Occupation:** | | | | **NOMINATED TREATING DOCTOR / SPECIALIST** | | | |
| **Email:** | | | | **Doctor's Name:** | | | |
| **EMPLOYER DETAILS** | | | | **Address Line 1:** | | | |
| **Company Name:** | | | | **Address Line 2:** | | | |
| **Contact Name:** | | | | **Suburb:** | | **Postcode:** | |
| **Address Line 1:** | | | | **Phone:** | | **Fax:** | |
| **Address Line 2:** | | | | **Mobile:** | | | |
| **Suburb:** | | **Postcode:** | | **Email:** | | | |
| **Phone** | | **Fax:** | | **INSURER DETAILS** | | | |
| **Mobile:** | | | | **Insurer:** | | | |
| **Email:** | | | | **Claim No:** | | | |
| **REASON FOR REFERRAL** | | | | **Case Manager:** | | | |
| _____ | | | | **Address Line 1:** | | | |
| _____ | | | | **Address Line 2:** | | | |
| **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, NTD, employer & WIRO.** | | | | **Phone:** | | **Fax:** | |
| | | | | **Mobile:** | | | |
| Signature: _____ | | | | **Case Manager email:** | | | |

**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 ☐ | |

**INSURER USE ONLY: Approval for Injury Management Services**

Workers Health Centre requests approval for the following services:

| | | | |
|---|---|---|---|
| Liability accepted: | Yes ☐ No ☐ | Same Employer Services | ☐ |
| Different Employer Services | ☐ | Single Rehabilitation Service/s | ☐ Details: |

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.

Signature: Employer / Insurer: Date:

**Please complete and return via fax to 02 9897 2488 *or* email admin@workershealth.com.au**
**Alternatively post to PO Box 123, Granville, NSW 2142 *or* drop off to 133 Parramatta Road, Granville, 2142**