WORKERS HEALTH CENTRE
People I Recovery I Work

Harris Park
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:	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 9054, Harris Park, NSW 2142 *or* **drop off to 7 Crown Street, Harris Park, 2150**

Harris Park Provider No: 619; Newcastle Provider No: 618