**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

WORKERS HEALTH CENTRE
People I Recovery I Work

# 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: | | Fax: | |
| Home Phone: | | Mobile: | | Mobile: | | | |
| Interpreter Required: | No | If yes language? | | Email: | | | |
| Occupation: | | | | **NOMINATED TREATING DOCTOR** | | | |
| 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, treating professionals & IRO.** | | | | 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 ☐ | |
| 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:
Different 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:

**Please complete and 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**

Parramatta Provider No: 619; Newcastle Provider No: 618