Referral Form

rehabco® 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 .....