

Referral for Clinical Consulting Services

Worker Details	
Surname	Phone number (W)
Mr/Mrs/Miss/Ms	(H)
First Name	Date of Birth
Address	Interpreter Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Email	Language
Occupation	
Employer	Insurer
Company	Company
RTW Coordinator	Contact
Supervisor / Manager	Claim Number
Address	Address
Phone	Phone
Fax	Fax
Email	Email
Injury Details	
Date of Injury _____	
Injury _____	
Nominated Treating Doctor	
Name	Phone
Address	Fax
Service(s) Required <i>(please tick)</i>	
<u>OCCUPATIONAL REHAB / CTP SERVICES</u> <input type="checkbox"/> Occupational Rehab Same employer case mgt <input type="checkbox"/> Occupational Rehab Different employer case mgt (INTEGRAIT) <input type="checkbox"/> Workplace Assessment – one off <input type="checkbox"/> Initial Assessment – one off <input type="checkbox"/> Ergonomic Assessment – one off <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Vocational Assessment <input type="checkbox"/> S40 Assessment <input type="checkbox"/> Home Assessment / ADL Assessment <input type="checkbox"/> Medical Case Conference	<u>MEDICAL & TREATMENT SERVICES</u> <input type="checkbox"/> Optimise Physiotherapy Functional Treatment Assessment <input type="checkbox"/> Optimise Physiotherapy Functional Treatment Program <input type="checkbox"/> Optimise Psychological Assessment <input type="checkbox"/> Optimise Psychological Treatment Services <input type="checkbox"/> Medical Assessment (Sports Physician) <input type="checkbox"/> Pre Employment Medical / Functional Assessment <input type="checkbox"/> Medical Advisory Board Assessment & Report <input type="checkbox"/> Activait Tail Management Program <input type="checkbox"/> Pre Liability Assessment <input type="checkbox"/> OTHER (please specify).....
COMMENTS	
Referred by	Title
Signature	Date