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|  |  | **UR:** \_\_\_\_\_**Surname:** \_\_\_\_\_**Given Name:** \_\_\_\_\_**Address:** \_\_\_\_\_**DOB:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Claim No.:** \_\_\_\_\_ |
| **Occupational Therapy Referral Form** |

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| **Provider name:** Health Enhance Occupational Therapy **Provider no.** 038**Provider address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone:** 1800 629856 **Email address:** RTW@Healthenhance.com.au |

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| **WORKER DETAILS** |

**1. Worker’s name:** \_\_\_\_\_  Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_ Claim Number**:** \_\_\_\_\_  Insurer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Injury Type: \_\_\_\_\_ Worker’s Address: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Pre-Injury Job Title: \_\_\_\_\_ Pre-Injury Work Hours: \_\_ **hours/week**Ceased Work Date: \_\_\_\_\_ Current Work Status: \_\_\_\_\_ RTW date (if applicable):\_\_\_\_\_ Current Hours of Work (if applicable): \_\_ **hours/week****REFERRAL DETAILS****2. Referring source:** ❑ Treating medical practitioner ❑ Insurer on behalf of employer (authority attached)❑ Employer❑ Conciliation and Review**Referrer details:** **Referral Form** Referrer name:\_\_\_\_\_ Organization: \_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_ C:\Users\miboujaoude\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\UZI7FHBI\42_as_Interleaved_2_of_5_barcode[1].jpg**3. Service request:**  |
|   |  ❑ ***OES (Old Employer Service) Assessment***❑ ***NES (New Employer Service) Assessment*****I have discussed this referral with:** ❑ **Employer**  ❑ **Treating Medical Practitioner** | **or** | ❑ ***Specific service: (please indicate)*** *(See over for further description)*❑ Functional Capacity Assessment❑ Ergonomic Assessment❑ Job Demands Assessment ❑ Workplace AssessmentOther:  |  |
|  ❑ I have discussed this referral with the worker and they are in agreement.Referrer’s Name: \_\_\_\_\_\_\_ Referrer’s Signature: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_  |
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| **EMPLOYER DETAILS** |

**4.** Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode: \_\_\_\_\_ Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_ Email: \_\_\_\_\_

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| **TREATING MEDICAL PRACTITIONER DETAILS** |

**5.** Dr’s Name: \_\_\_\_\_Practice Name: \_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_ Telephone: \_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **6. Section to be completed by vocational rehabilitation provider:** Has a vocational rehabilitation programme previously been undertaken with you or another provider? Yes ❑ No❑ Interpreter required? ❑ Yes ❑ No Date of worker’s last recurrence: \_\_\_\_\_Referral Type: ❑ Assessment ❑ Specific Service Date referral received: Did this current referral proceed to assessment/specific service? Yes ❑ No ❑ If **No** please indicate: ❑ 1st Schedule Redemption ❑ 2nd Schedule Settlement ❑ Common Law Election Other Costs incurred:  |
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**Rehabilitation Provider: Please enter details into the Online Rehabilitation application within 28 days of receipt of referral and
retain copy on worker’s file**