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|  |  | **UR:** \_\_\_\_\_**Surname:** Stojanovic**Given Name:** Jelena**Address:** 45 David St [Insert suburb]**DOB:** 14/3/19\_\_ **Sex:** F **Claim No.:** M\_004900  |
| **Occupational Therapy Referral Form** |

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| **Provider name:** Health Enhance Occupational Therapy **Provider no.** 038**Provider address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone:** 1800 629 856 **Email address:** RTW@Healthenhance.com.au |

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| **WORKER DETAILS** |

**1. Worker’s name:** Ms Jelena Stojanovic  Date of Birth: 14/3/19\_\_ Telephone Number: 0427 641 334 Claim Number**:** M\_004900 Insurer: Nil Date of Injury: 5 March 20\_\_Injury Type: Carpal tunnel syndrome R) handWorker’s Address: 45 David Street, [Insert suburb]\_State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Pre-Injury Job Title: Patient service assistant Pre-Injury Work Hours: 38 **hours/week**Ceased Work Date: 5/3/20\_\_\_\_\_\_\_ 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:Dr [Insert name]Organization: Medical One Centre Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_ Telephone: \_\_\_\_\_ Mobile: [Insert contact number]Email: \_\_\_\_\_ 42_as_Interleaved_2_of_5_barcode[1]**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 Assessment

Other:  |  |
| * I have discussed this referral with the worker and they are in agreement.

Referrer’s Name: Dr [Insert name] Referrer’s Signature: Dr [Insert name] \_\_\_\_\_\_\_ Date: **13.9.20\_\_**  |
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| **EMPLOYER DETAILS** |

**4** Company Name: **[Insert organisation name]**Address: \_\_\_\_\_\_\_\_**[Insert address]**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Postcode: \_\_\_\_ Contact Name: **[Insert name]** Telephone: \_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TREATING MEDICAL PRACTITIONER DETAILS** |

**5.** Dr’s Name: **Dr [Insert name]**Practice Name: **Medical One Centre**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: Telephone: **1800 326 987** Mobile: \_**[Insert contact number]\_\_\_\_\_\_** 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.**