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|  |  | **UR:** **Surname:** McRae **Given Name:** Joyce **Address:** 6/75 Cambridge Street [Insert Suburb]**DOB:** 02.07.19\_\_ **Sex:** F **Claim No.:** M\_007654  |
| **Occupational Therapy Referral Form** |

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

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| **WORKER DETAILS** |

**1. Worker’s name:** Joyce McRae  Date of Birth: 2nd July, 19\_\_ Telephone Number: 0427 641 334Claim Number**:** M\_007654 Insurer: Allianz Date of Injury: 5 March 20\_\_ Injury Type: Bilateral Lateral EpicondylitisWorker’s Address: 6/75 Cambridge Street, [Insert suburb] State: \_\_\_\_\_ Postcode: \_\_\_\_\_ Pre-Injury Job Title: Food Service Assistant Pre-Injury Work Hours: 38 **hours/week**Ceased Work Date: 5 March 20\_\_ Current Work Status: FTRTW 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: Midtown Medical CentreAddress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_ Telephone: [Insert contact number]Mobile: 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: 23.9.20\_\_ |
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| **EMPLOYER DETAILS** |

**4.** Company Name: [Insert organisation name]Address: [Insert address] Postcode: \_\_\_\_\_Contact Name: [Insert name]Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **TREATING MEDICAL PRACTITIONER DETAILS** |

**5.** Dr’s Name: **Dr [Insert name]**Practice Name: **Midtown Medical Centre**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_ Telephone: [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**