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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](mailto: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 641 334  Claim Number**:** M\_007654 Insurer: Allianz Date of Injury: 5 March 20\_\_  Injury Type: Bilateral Lateral Epicondylitis  Worker’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: FT  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: Midtown Medical Centre  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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\_\_ | | | | |
| |  | | --- | | **EMPLOYER DETAILS** |   **4.** Company Name: [Insert organisation name]  Address: [Insert address] Postcode: \_\_\_\_\_  Contact Name: [Insert name]  Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **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**