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|  |  | **UR:**  **Surname:** Cummins  **Given Name:** Marie  **Address:** 45 Grove Street, [insert]  **DOB:** 12.04.19\_\_ **Sex:** F  **Claim No.:** M\_001122 |
| **Occupational Therapy Referral Form** | |

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| **Provider name:** Health Enhance Occupational Therapy **Provider no.** 038  **Provider address:** [Insert address]  **Telephone:** [Insert contact number] **Email address:** [RTW@Healthenhance.com.au](mailto:RTW@Healthenhance.com.au) |

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| |  | | --- | | **WORKER DETAILS** |   **1. Worker’s name:** Mrs. Marie Cummins  Date of Birth: 12.04.19\_\_ Telephone Number: \_\_ 0427 641 334  Claim Number**:** M\_001122 Insurer: QBE Date of Injury: [Insert date]  Injury Type: Low Back Pain, L4/5 disc herniation  Worker’s Address: 45 Grove Street, [Insert suburb]\_\_\_\_\_\_\_\_\_\_\_ State: \_**[Insert]**\_ Postcode: **[Insert]**  Pre-Injury Job Title: **Instrument Technician Grade One** \_\_\_\_\_ Pre-Injury Work Hours:\_**38 hours/week**  Ceased Work Date:\_\_**26 March 20\_\_**\_ Current Work Status \_\_\_\_**Fulltime**  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:**  Referrer name: **Dr [Insert name]** Organization: \_\_\_\_ **Southern Cross Medical Centre**  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_  Telephone: **1800 326 987** Mobile: **[Insert contact number]**\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **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: [Insert date] | | | | |
| |  | | --- | | **EMPLOYER DETAILS** |   **4** Company Name: **[Insert organisation name]**  Address: \_\_\_\_\_\_\_\_\_**[Insert address]**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_ Postcode:  Contact Name: **[Insert name]**  Telephone: \_\_\_\_\_\_\_\_\_\_\_Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  | | --- | | **TREATING MEDICAL PRACTITIONER DETAILS** |   **5.** Dr’s Name: **Dr [Insert name]** Practice Name: \_\_\_\_\_ **Southern Cross Medical 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**