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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 |

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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 herniationWorker’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] |
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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: \_\_\_\_\_ **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**