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|  |  | **UR:** \_\_\_\_\_  **Surname:** \_\_\_\_\_  **Given Name:** \_\_\_\_\_  **Address:** \_\_\_\_\_  **DOB:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Claim No.:** \_\_\_\_\_ |
| **Occupational Therapy Referral Form** | |

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| **Provider name:** Health Enhance Occupational Therapy **Provider no.** 038  **Provider address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone:** 1800 629856 **Email address:** RTW@Healthenhance.com.au |

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| |  | | --- | | **WORKER DETAILS** |   **1. Worker’s name:** \_\_\_\_\_    Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  Claim Number**:** \_\_\_\_\_  Insurer: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  Injury Type: \_\_\_\_\_  Worker’s Address: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_  Pre-Injury Job Title: \_\_\_\_\_ Pre-Injury Work Hours: \_\_ **hours/week**  Ceased Work Date: \_\_\_\_\_ 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:\_\_\_\_\_ Organization: \_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_  Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_  C:\Users\miboujaoude\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\UZI7FHBI\42_as_Interleaved_2_of_5_barcode[1].jpg**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: \_\_\_\_\_\_\_ Referrer’s Signature: \_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_ | | | | |
| |  | | --- | | **EMPLOYER DETAILS** |   **4.** Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postcode: \_\_\_\_\_  Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone:\_\_\_\_\_ Email: \_\_\_\_\_   |  | | --- | | **TREATING MEDICAL PRACTITIONER DETAILS** |   **5.** Dr’s Name: \_\_\_\_\_  Practice Name: \_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_  Telephone: \_\_\_\_\_ 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**