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|  |  | **UR:** \_\_\_\_\_  **Surname:** Stojanovic  **Given Name:** Jelena  **Address:** 45 David St [Insert suburb]  **DOB:** 14/3/19\_\_ **Sex:** F **Claim No.:** M\_004900 |
| **Occupational Therapy Referral Form** | |

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| **Provider name:** Health Enhance Occupational Therapy **Provider no.** 038  **Provider address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone:** 1800 629 856 **Email address:** [RTW@Healthenhance.com.au](mailto:RTW@sunnybrookhealthcare.com.au) |

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| |  | | --- | | **WORKER DETAILS** |   **1. Worker’s name:** Ms Jelena Stojanovic    Date of Birth: 14/3/19\_\_ Telephone Number: 0427 641 334  Claim Number**:** M\_004900 Insurer: Nil Date of Injury: 5 March 20\_\_  Injury Type: Carpal tunnel syndrome R) hand  Worker’s Address: 45 David Street, [Insert suburb]\_State: \_\_\_\_\_ Postcode: \_\_\_\_\_  Pre-Injury Job Title: Patient service assistant Pre-Injury Work Hours: 38 **hours/week**  Ceased Work Date: 5/3/20\_\_\_\_\_\_\_ 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:Dr [Insert name]Organization: Medical One Centre  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_ Postcode: \_\_\_\_\_  Telephone: \_\_\_\_\_ Mobile: [Insert contact number]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: **13.9.20\_\_** | | | | |
| |  |  |  | | --- | --- | --- | | |  | | --- | | **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: **Medical One Centre**  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State: \_\_\_\_\_\_\_ Postcode:  Telephone: **1800 326 987** Mobile: \_**[Insert contact number]\_\_\_\_\_\_** Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  | | --- | | **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: \_\_\_\_\_\_ | | | | | |

**Rehabilitation Provider: Please enter details into the Online Rehabilitation application within 28 days of receipt of referral and   
retain copy on worker’s file.**