

REFERRAL / APPROVAL FOR OCCUPATIONAL REHABILITATION SERVICES

WORKER

Surname	_____	First name	_____
Phone (h)	_____	Phone (w)	_____
Address	_____		
Occupation	_____	Mobile :	_____
		Interpreter Required ?	_____

INJURY

Date of Injury	_____
Nature of injury	_____
Claim No	_____

EMPLOYER

Name	_____	Email	_____
Phone	_____	Fax	_____
Address	_____		

LOCAL CONTACT (if applicable)

Name	_____	Email	_____
Phone	_____	Fax	_____
Address	_____		

INSURER

Name	_____		
Phone	_____	Fax	_____
Address	_____		

NOMINATED TREATING DOCTOR

Name	_____		
Phone	_____	Fax	_____
Address	_____		

SERVICES REQUIRED (please indicated with X in front of service required)

<input type="checkbox"/>	Assess Rehabilitation Needs	<input type="checkbox"/>	Assess Workstation Ergonomics
<input type="checkbox"/>	Evaluate the Workplace	<input type="checkbox"/>	Assess Functional Needs
<input type="checkbox"/>	Develop Return to Work Plan		

Other (please specify) _____

Liability Accepted ? (Delete not applicable)	Yes	No	Don't know
Previous rehabilitation (Delete not applicable)	Yes	No	Don't know
Cost of rehabilitation to date	\$ _____		

Approval is hereby given for you to undertake Occupational Rehabilitation Services up to the development of a Rehabilitation Plan or as otherwise specified.

Name	_____	Date	_____
Signature	_____	Title	_____