



Referral Form (page 1 of 4)

<i>Employee name:</i>		<i>Date of referral:</i>	
<i>Employee address:</i>		<i>Home phone:</i>	
		<i>Work/other phone:</i>	
<i>Date of birth:</i>		<i>Gender:</i>	Male: <input type="checkbox"/> Female: <input type="checkbox"/>
<i>Employee's job title:</i>			
<i>If interpreter required, please specify language:</i>			

Employer details:

<i>Company name:</i>			
<i>Workplace address:</i>			
<i>Workplace contact:</i>			
<i>Role of workplace contact:</i>			
<i>Phone:</i>		<i>Fax:</i>	

<i>Employee's pre-injury/usual employment status:</i>	<i>Hours per day</i>	<i>Days per week</i>	<i>Hours per week</i>		
<i>Employee's current employment status:</i>	<i>Hours per day</i>	<i>Days per week</i>	<i>Normal duties</i>	<i>Modified duties</i>	<i>Alternative duties</i>

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Medical Practitioner contact details:

<i>Name:</i>			
<i>Address:</i>			
<i>Phone:</i>		<i>Fax:</i>	

Other Treating Practitioner contact details:

<i>Name:</i>			
<i>Address:</i>			
<i>Phone:</i>		<i>Fax:</i>	
<i>Type of treatment:</i>			

Other Treating Practitioner contact details:

<i>Name:</i>			
<i>Address:</i>			
<i>Phone:</i>		<i>Fax:</i>	
<i>Type of treatment:</i>			

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Referral details:	
<i>Is this referral made as a result of an injury/incident?</i>	
<i>Date of injury/incident:</i>	
<i>How did the injury/incident occur?</i>	
<i>Diagnosis:</i>	
<i>Current restrictions: (please attach supporting documentation)</i>	
<i>Additional information:</i>	

Claim details:	
<i>Nature of matter:</i>	Compensation <input type="checkbox"/> Non-compensation <input type="checkbox"/> Pending <input type="checkbox"/>
<i>Claim number:</i>	
<i>Additional information:</i>	

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Rehabilitation services required:

	Initial needs assessment (<i>with possible ongoing RTW services</i>)
	Ergonomic workstation assessment:
	Task analysis:
	Redeployment services: (<i>specific details of services to be discussed upon receipt of referral</i>)
	Other (please provide comments): (<i>specific details of services to be discussed upon receipt of referral</i>)

Referrer signature:	
Referrer name:	
Date:	

Please send completed referral form to Work Life Tasmania,
either by fax: **(03) 6223 3804**
or email: marcus@worklifetas.com.au

Please direct any enquiries to Marcus Hardwick, Manager, Work Life Tasmania
by phone: **0488 266 105**