WORKPLACE REHABILITATION REFERRAL FORM

Workplace Rehabilitation Provider	**Pace National**

Case Details

Worker's Name			
Date of Birth		**Phone Number**	
Address			
Email			
Insurer		**Claim Number**	
Insurer Contact		**Phone/Email**	
Injury Type		**Date of Injury**	
Occupation			

Referral

☐ **Specific Service only** [Select from list on right if an individual service only is required]	☐ Initial Assessment ☐ Vocational Assessment ☐ Ergonomic Assessment ☐ Aids & Appliances	☐ Functional Capacity Assessment ☐ Workplace/ Worksite Assessment ☐ Job Demands Assessment
☐ **Workplace Rehabilitation Program**	[Select for full workplace rehabilitation services and program development]	

Status of Worker

☐ Working / Full Capacity	☐ Not Working / Full Capacity	☐ Not Working / No Capacity
☐ Working / Partial Capacity	☐ Not Working / Partial Capacity	

Employer Details

Company			
Contact Name		Role	
Address			
Phone		Email	

Medical Practitioner

Practice			
Practitioner Name			
Address			
Phone		Email	

Source of Referral

☐ Employer	☐ Medical Practitioner	☐ Insurer	☐ Legal Representative/Worker

Referrer

☐ I have discussed this referral with the Worker and their ☐ Employer ☐ Medical Practitioner ☐ Broker ☐ Insurer

☐ I have attached relevant documentation such as medical certificates, injury details, case notes, etc.

Signature			
Name		Organisation	
Phone Number		Referral Date	
Email			

If for Worker's Compensation: Insurer, please submit to WorkCover WA Online Portal