|  |  |
| --- | --- |
| **Workplace Rehabilitation Provider** |  |

**Details**

|  |  |
| --- | --- |
| **Worker’s Name** |  |
| **Insurer** |  |
| **Claim Number** |  |
| **Date of Injury** |  |
| **Phone** |  |

**Referral**

|  |  |  |
| --- | --- | --- |
| **Specific Service** | Functional Capacity  Vocational  Ergonomic | Job Demands  Workplace  Aids & Appliances |
| **Rehabilitation Program** | | |

**Status of Worker**

|  |  |
| --- | --- |
| Working / Full Capacity  Working / Partial Capacity | Not Working / Full Capacity  Not Working / Partial Capacity  Not Working / No Capacity |

**Employer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Company |  | | |
| Contact Name |  | | |
| Address |  | | |
| Phone |  | Email |  |

**Medical Practitioner**

|  |  |  |  |
| --- | --- | --- | --- |
| Practice |  | | |
| Name |  | | |
| Address |  | | |
| Phone |  | Email |  |

**Source of Referral**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Practitioner | Employer | Insurer | Legal Representative/Worker |

**Referrer**

|  |  |
| --- | --- |
| Signature |  |
| Name |  |
| Date |  |

**Insurer – Submit referral into WorkCover WA Online**

**Employer, Medical Practitioner and Worker – Provide form to the Insurer or WRP**

**WRP – Provide form to the Insurer**