|  |  |
| --- | --- |
| **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**