Procare group

Integrated Insurance Solutions

Injury Management Referral Form

REFERRER DETAILS:

First Name: | Last Name:

Job Title: | Company

E-Mail: | Contact#:

Date of Referral (DD/MM/YYYY) | Who is paying for the service: ⊙ Employer ○ Insurer

SERVICE REQUIRED:

Please select the services required from the following options and also indicate whether your request is urgent or routine, and requires a specific timeframe.

- ☐ Case Management Same Employer
- ☐ Case Management Different Employer
- ☐ Initial Needs Assessment
- ☐ Activities of Daily Living Assessment
- ☐ Workplace Assessment
- ☐ Ergonomic Assessment
- ☐ Functional Assessment
- ☐ Section 53 Assistance for Equipment
- ☐ Vocational Assessment
- ☐ Job Seeking Strategy
- ☐ Job Club
- ☐ Section 53 Assistance for Retraining
- ☐ Functional Capacity / Section 40 Assessment
- ☐ Medical Management
- ☐ Catastrophic Claim
- ☐ Mediation
- ☐ Other (specify)

Purpose of referral:

Additional Timeframe Requirements:

WORKER DETAILS:

First Name: | Last Name:

Gender | Salutation

Date of Injury: (DD/MM/YY) | Claim Number:

Nature of Injury:

Home Address:

Suburb: | State: | Postcode:

Home Number: | Work: Number:

Mobile Number:

Date of Birth: (DD/MM/YY)

Email: | Pre-Injury Occupation:

Work Status: | ☐ Interpreter Required?

Language:

EMPLOYER DETAILS:

Business Name: | Email:

Contact Name: | Position:

Mailing Address:

Suburb: | State: | Postcode:

Phone: | Fax:

Employee Workplace Same as Employer Address? ☐
Address:

Workplace Address:

Suburb: State: Postcode:

Phone: Fax:

INSURER DETAILS:

Name: Notification Date: (DD/MM/YY)

Company

Email:

Phone: Fax:

NOMINATED TREATING DOCTOR DETAILS:

Name:

Mailing Address:

Suburb: State: Postcode:

Phone: Fax:

Email:

ATTACHMENTS TO THIS REQUEST

☐ Compensation Claim Form
☐ Employers Injury Report Form
☐ Medical Certificate(s)
☐ Other (nominate)

SPECIFIC INSTRUCTIONS/GENERAL COMMENTS

Please return via one of the following methods:
Email: referrals@procaregroup.com.au
Fax: (02) 9086 8001