



Investigation Referral Form

INVESTIGATION REFERRAL

SERVICE REQUIRED

SURVEILLANCE: Hours:

FACTUAL:

STRESS ASSESSMENT:

WITNESS LOCATION:

*Date Instructions Sent (today's date):

Date Report Due:

CLAIM DETAILS

Claim Number:

Date of Incident:

Date Reported:

*Injury Type (back, psych):

Circumstances of Incident:

Current Work Status: Totally Unfit
 Suitable duties
 Full duties
 No longer employed

Roster (if working):

CLAIMANT'S CONTACT DETAILS

Gender: Select

Salutation: Select

First Name:

*Surname:

*Date of Birth:

Home Address:

Telephone Number: (h): (w) (m)

Email:

Interpreter Req'd y n

Language Spoken

EMPLOYER'S CONTACT DETAILS

Company Name:

Contact Person's First Name:

Contact Person's Surname:

Position:

Email address:

Telephone Number(s): (w) (m)

REFERRER'S CONTACT DETAILS

*Referrer's First Name:

*Referrer's Surname:

Invoice Reference Number(if different to a claim number):

*Telephone Number:

Mobile (if applicable):

*E-mail Address:

Broker Firm (if applicable):

Broker's Full Name (if applicable):

CLAIMANT'S DETAILS (SURVEILLANCE/LOCATION ONLY)

Height:

Weight:

Build:

Hair Colour:

Country of birth:

Car details (make, model, colour, rego):

Dependants (name, sex, date of birth):

Marital Status: Select

Spouse working: Yes No Unknown N/A

General Comments/Distinguishing Features (i.e. body marking, glasses, jewellery):

ATTACHMENTS TO THIS REQUEST

Compensation Claim Form
Medical Certificate(s)

Employer's Injury Report Form
Other (nominate)

SPECIFIC INSTRUCTIONS / GENERAL COMMENTS

Please identify in the Comments Box below, any specific instructions that you would like addressed in our investigation, such as the identification of specific interviewees, collection of specific documentation, recovery, work injury damages, photographic/video evidence, etc.

Comments:

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