

NORTHERN REHABILITATION MANAGEMENT

Workplace Rehabilitation Services

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REFERRAL FOR OCCUPATIONAL REHABILITATION SERVICES

Worker's Name: _____ Date of Birth: ____/____/____

Worker's Address: _____
_____ PCode _____

Phone No: _____ Mobile: _____

Occupation: _____ At Work: YES NO CEASED

Date of Injury: ____/____/____ Type of Injury: _____

Employer: _____

Employer Address: _____
_____ PCode _____

Employer RTW Co-Ord: _____

Phone No: _____ Mobile: _____

Fax No: _____ Email: _____

Treating Doctor: _____

Doctor Address: _____
_____ PCode _____

Phone No: _____ Mobile: _____

Fax No: _____ Email: _____

Insurance Co: _____ Claim Number: _____

Insurer Address: _____
_____ PCode _____

Insurer Case Manager / Contact: _____

Phone No: _____ Mobile: _____

Fax No: _____ Email: _____

Liability Accepted: YES NO UNKNOWN Previous Rehab: YES NO

Comments/Instructions: _____

Approval is hereby given for you to undertake Occupational Rehabilitation services up to the development of a Rehabilitation Plan or as otherwise specified.

Signed: _____ Title: _____

Print Name: _____

On behalf of: INSURER EMPLOYER

Date: ____/____/____