Referral / approval for occupational rehabilitation services

TOP COPY: To Provider 2nd COPY: Insurers/Employers 3rd COPY: File Copy

Provider's name ______

Address ______ Post code ______

Phone ______ Fax ______

Worker's name ______ Date of birth DD / MM / YY

Address ______ Post code ______

Phone ______ Mobile ______

Date of injury DD / MM / YY Type of injury ______

Diagnosis ______ Occupation ______

Treating doctor ______ Phone ______ Fax ______

Address ______ Post code ______

Interpreter required ☐ Yes ☐ No Language ______

At work ☐ Off work ☐ Ceased DD / MM / YY Terminated ☐ Yes ☐ No

Employer's name ______

Return to work coordinator ______

Phone ______ Fax ______

Address ______ Post code ______

Claim number ☐ Claim assessor ______ Phone ______

Liability accepted ☐ Yes ☐ No ☐ Don't know ☐ Specific services required (Please detail) ______

______

Comments ______

______

Previous rehabilitation ☐ Yes ☐ No Cost to date $ ☐ Attached Reports ☐ Yes ☐ No Certificates ☐ Yes ☐ No

Approval is hereby given for you to undertake occupational rehabilitation services up to a rehabilitation plan or as otherwise specified:

Signature ______ Date DD / MM / YY

Name ______

Title ______ (For employer/insurer)

All services will be reviewed in accordance with the Hotel Employers Mutual Service Standards for Rehabilitation Providers.
A copy of these standards may be obtained by contacting Hotel Employers Mutual or on the website.