PHONE: 1300 762 989 FAX: 1300 762 654
Email completed form to: referrals@rehabmanagement.com.au

LIFE INSURANCE REFERRAL FORM

MEMBER / CLAIMANT DETAILS

Name: Claim Number:

Address:

D.O.B: Date of Claim:

Nature of Injury: Telephone:

Mobile: Email:

EMPLOYMENT (if job attached)

Employer: Worksite Location:

Address:

Supervisor / RTW Coordinator: Email:

Phone: Fax:

Employment Status: At Work [ ] Off work [ ] Terminated [ ]

INSURER CONTACT DETAILS

Insurer: Rehab Consultant:

Phone: Email:

Case Manager:

Claim Accepted: Yes / No Other Claims: Yes / No

TREATING MEDICAL PRACTITIONER

Name: Telephone:

Address:

Email: Fax:

TREATING ALLIED HEALTH PROFESSIONAL

Name: Telephone:

Address:

Email: Fax:

REFERRAL

[ ] Initial Needs Assessment
[ ] Workplace Assessment
[ ] Initial Psychological Assessment
[ ] ADL Assessment
[ ] Medical Case Conference
[ ] Functional Assessment
[ ] Other (Please specify)

[ ] Vocational Assessment
[ ] Job Task Analysis
[ ] Transferable Skills Analysis
[ ] Vocational Counselling
[ ] Desktop Employability Assessment
[ ] Face to Face Employability Assessment

[ ] Initial Work Conditioning Assessment
[ ] Redeployment / Job Seeking
[ ] Ergonomic Assessment
[ ] Work Trial Hosting
[ ] Labour Market Review
[ ] RTW Assistance

APPROVAL OF COSTS

Hours Pre-Approved: Hours - Or Amount (GST Inclusive):

Report Required: Yes / No

Approval Signature and Date: