

Workplace rehabilitation provider:

### DETAILS

Worker name:  Date of birth:

Claim number:  Date of injury:

Address:

Email:

Phone number:  Insurer:

### REFERRAL

**Specific service (select which applies)**

Functional capacity

Vocational

Workplace

Job demands

Ergonomic

Aids & Appliances

**Rehabilitation program**

### STATUS OF WORKER

Not working / full capacity

Working / full capacity

Not working / partial capacity

Working / partial capacity

No working / no capacity

### EMPLOYER DETAILS

Company:

Contact name:  Phone number:

Address:

Email:

### MEDICAL PRACTITIONER

Company:

Contact name:  Phone number:

Address:

Email:

### SOURCE OF REFERRAL

Medical practitioner

Employer

Insurer

Worker / representative

### REFERRER

Name:  Date:

Signature:

Employer, medical practitioner, and worker – provide form to the insurer or WRP.

WRP – provide form to the insurer.

Insurer – submit referral into WorkCover WA Online.