fastrack health

Speedy health solutions to keep your business on track

fastrackhealth.com.au

REFERRAL FORM

REFERRAL DATE

Referred by _____ **Company** _____ **Signature** _____

Phone _____ Mobile _____ Email _____

REFERRED FOR

Single Rehabilitation Service

- ☐ Workplace Assessment
- ☐ Vocational Assessment
- ☐ Functional Assessment
- ☐ Other: _____

Return to Work Plan

- ☐ Same Employer
- ☐ Different Employer

SCHEME

- ☐ WorkCover ☐ CTP

SERVICE LOCATION

Providing services across NSW

Other Service

- ☐ Return to Work Coordination
- ☐ S40 Assessment / Earning Capacity Assessment
- ☐ Job Seeking Assistance Program
- ☐ Psychological Assessment / Counselling / Trauma Debriefing
- ☐ Ergonomic Assessment
- ☐ Activities of Daily Living Assessment
- ☐ Pain Management
- ☐ Other: _____

WORKER DETAILS

First Name _____ Surname _____

Date of Birth _____ Claim No. _____

Address _____

Phone _____ Mobile _____ Email _____

Type of Injury _____ Date of Injury _____

Occupation _____

Interpreter Required: No ☐ Yes ☐ Language _____

NOMINATED TREATING DOCTOR

Doctor _____ Phone _____ Fax _____

Address _____

EMPLOYER DETAILS

Employer _____ Contact Name _____

Phone _____ Fax _____ Email _____

Address _____

INSURER DETAILS

Insurer _____ Contact Name _____

Phone _____ Fax _____ Email _____

Address _____