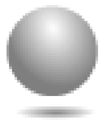

Dynamic Recovery

Occupational Rehabilitation

Referral Form (page 1 of 4)

Employee name:		*Date of referral:*	
Employee address:		*Home phone:*	
		Work/other phone:	
Date of birth:		*Gender:*	Male: ☐ Female: ☐
Employee's job title:			
If interpreter required, please specify language:			

Employer details:			
Company name:			
Workplace address:			
Workplace contact:			
Role of workplace contact:			
Phone:		*Fax:*	

Employee's pre-injury/usual employment status:	*Hours per day*	*Days per week*	*Hours per week*		
Employee's current employment status:	*Hours per day*	*Days per week*	*Normal duties*	*Modified duties*	*Alternative duties*

Referral Form (page 2 of 4)

Medical Practitioner contact details:			
Name:			
Address:			
Phone:		*Fax:*	

Other Treating Practitioner contact details:			
Name:			
Address:			
Phone:		*Fax:*	
Type of treatment:			

Other Treating Practitioner contact details:			
Name:			
Address:			
Phone:		*Fax:*	
Type of treatment:			

Referral Form

Referral details:	
Is this referral made as a result of an injury/incident?	
Date of injury/incident:	
How did the injury/incident occur?	
Diagnosis:	
Current restrictions: (please attach supporting documentation)	
Additional information:	

Claim details:	
Nature of matter:	Compensation ☐ Non-compensation ☐ Pending ☐
Claim number:	
Additional information:	

Referral Form (page 4 of 4)

Rehabilitation services required:	
	Initial needs assessment *(with possible ongoing RTW services)*
	Ergonomic workstation assessment:
	Task analysis:
	Redeployment services: *(specific details of services to be discussed upon receipt of referral)*
	Other (please provide comments): *(specific details of services to be discussed upon receipt of referral)*

Referrer signature:	
Referrer name:	
Date:	

Please send completed referral form to Dynamic Recovery,
either by fax: **(03) 62236439**
or email: jodie@dynamicrecovery.com.au

Please direct any enquiries to Jodie Hardwick, Manager, Dynamic Recovery
by phone: **0439 393 058**