

## WORKPLACE REHABILITATION PROVIDER SERVICE DELIVERY PLAN

This template is to be completed by the workplace rehabilitation provider to comply with Standard 3.5 of the *Workplace Rehabilitation Providers Principles and Standards of Practice*. The service delivery plan (SDP) must be provided within seven (7) days of the completion of the initial assessment.

DETAILS	S							
Provider:				Num	Number:			
Worker name:					Date	Date of birth:		
Work status at re		eferral:			Pre-i	Pre-injury hours:		
Employer:					Refe	Referral date:		
Claim number:								
ASSESSMENT SERVICES								
Please indicate those prescribed services undertaken to complete assessment.								
Item	Code	Prescribed Service	Cost (\$)	Item	Code	Prescribed Service	Cost (\$)	
2	WRP02	Vocational counselling		8	WRP08	Assessment of functional capacity		
4	WRP04	Case management		9	WRP09	Vocational assessment		
6	WRP06	Workplace activities		10	WRP10	Ergonomic assessment		
14	WRP14	Travel		11	WRP11	Assessment of job demands		
15	WRP15	Medical		12	WRP12	Workplace assessment		
17	WRP17	Report						
Total assessment of cost (GST excl.)								
PROPO:	SED REH	ABILITATION GO	AL					
Employe	er:							
Duties:	es:							
Proposed dates of program: Goal hours:								
PROPOSED SERVICE DELIVERY								
Hourly rate prescribed by WorkCover WA   \$								

Hourly rate prescribed by WorkCover WA						
Item	Code	Prescribed Service	Estimate of hours	Estimated completion time	Estimated costs	
1	WRP01	Support counselling				
2	WRP02	Vocational counselling				
3	WRP03	Purchase of aids & appliances				
4	WRP04	Case management				
5	WRP05	Training & education				
6	WRP06	Workplace activities				
7	WRP07	Placement activities				

Item	Code	Prescribed Service	Estimate of hours	Estimated completion time	Estimated costs	
8	WRP08	WRP08 Assessment of functional capacity				
9	WRP09	Vocational assessment				
10	WRP10	Ergonomic assessment				
11	WRP11	Assessment of job demands				
12	WRP12	Workplace assessment				
13	WRP13	Aids & appliances assessment				
14	WRP14	Travel				
15	WRP15	Medical				
16	WRP16	Return to work case conference				
17	WRP17	Report				
				Total hours:		
	Plan cost:					
	Total cost (including assessment):					
Worker sig	gnature:	Date:				
SDP ame	ndment:					
Reason:						
Consultant name:		Date:				

Consultant signature: