GOVERNMENT OF WESTERN AUSTRALIA | WorkCoverWA

WORKPLACE REHABILITATION REFERRAL

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: ______ ABN: ______

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.