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:

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.