WORK ABLE CONSULTING OCCUPATIONAL REHABILITATION REFERRAL FORM

Please email completed form to referrals@workableconsulting.com.au
Phone: 03 9686 7866 | Fax: 03 9686 0066

Date of Referral: _____

Service Required: _____

Preferred Work Able Consulting Location: _____

Medical Information Attached:

Certificate of Capacity ☐ THP Report ☐ IME Extract ☐ Other Medical Reports ☐

Referrer Details:

Company Name:	
Contact Person:	
Phone Number:	
Email Address:	
Invoices to be sent to:	

Employers Details: (if different from above)

Company Name:	
Contact Person:	
Phone Number:	
Email Address:	

Worker Details:

Name:	
Phone Number:	
Residential Address:	
Email Address:	
Pre-Injury Job Title:	

Claim Details:

Claim Number:	
Date of Injury:	
Ceased Work Date:	
Current Work Status:	
Current Work Hours per Week:	
Injury Type:	
Is the Worker flagged as at risk? If so, please provide details	

Additional Information:

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