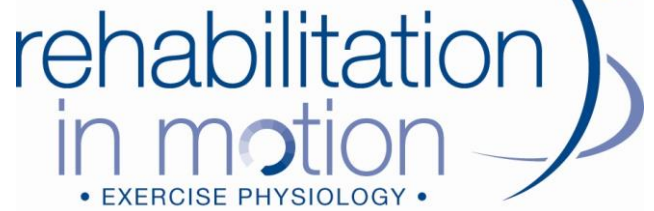


# Referral for Work Conditioning

(for CTP and Workers Compensation clients)



Please complete and fax back to Rehabilitation in Motion  
on **(02) 4225 2081** or  
email to [katerina@rehabilitationinmotion.com.au](mailto:katerina@rehabilitationinmotion.com.au)

Ph: (02) 4229 9555  
Fax: (02) 4225 2081  
Address: Suite 6, 25 Victoria St, WOLLONGONG NSW 2500

<b>Referred by:</b>	
Name: _____	Tel: _____
Position: _____	Fax: _____
Organisation: _____	Email: _____
Address: _____	
_____	
<b>Insurer/Account details:</b>	<b>Approval given for:</b>
Claim number: _____	Initial Assessment <input type="checkbox"/>
Organisation: _____	Full Program <input type="checkbox"/>
Claim Manager: _____	Approval request <input type="checkbox"/>
Tel: _____	
Fax: _____	
Postal Address: _____	
_____	
<b>Client details:</b>	<b>Employment details:</b>
Name: _____	Occupation: _____
Surname: _____	Employer: _____
DOB: _____	Contact Person: _____
DOI: _____	Position: _____
Address: _____	Phone: _____
Tel: _____	Fax: _____
Mobile: _____	Email: _____
<b>Rehabilitation Goal:</b>	
Pre-injury duties <input type="checkbox"/> Redeploy <input type="checkbox"/> Improve injury self-management <input type="checkbox"/>	
<b>Comments:</b>	
_____	
_____	
<b>Diagnosis:</b>	
Nature of injury/ diagnosis: _____	
_____	
Treatment to date: <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Osteopathy <input type="checkbox"/> Other: _____	
<b>Treating doctor:</b>	
GP name: _____	Address or surgery stamp: _____
Tel: _____	_____
Fax: _____	_____
GP is aware that patient will be attending program Yes <input type="checkbox"/> No <input type="checkbox"/>	