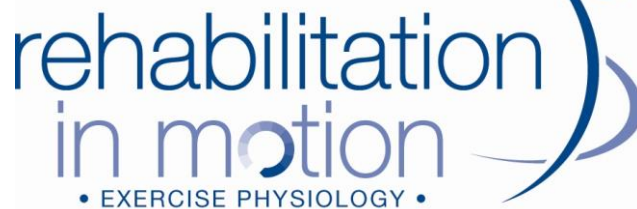


Referral for Work Conditioning

(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

Ph: (02) 4229 9555
Fax: (02) 4225 2081
Address: Suite 3/8-10 Victoria St, WOLLONGONG NSW 2500

Referred by:	
Name: _____	Tel: _____
Position: _____	Fax: _____
Organisation: _____	Email: _____
Address: _____	

Insurer/Account details:	Approval given for:
Claim number: _____	Initial Assessment <input type="checkbox"/>
Organisation: _____	Full Program <input type="checkbox"/>
Claim Manager: _____	Approval request <input type="checkbox"/>
Tel: _____	
Fax: _____	
Postal Address: _____	

Client details:	Employment details:
Name: _____	Occupation: _____
Surname: _____	Employer: _____
DOB: _____	Contact Person: _____
DOI: _____	Position: _____
Address: _____	Phone: _____
Tel: _____	Fax: _____
Mobile: _____	Email: _____
Rehabilitation Goal:	
Pre-injury duties <input type="checkbox"/> Redeploy <input type="checkbox"/> Improve injury self-management <input type="checkbox"/>	
Comments:	

Diagnosis:	
Nature of injury/ diagnosis: _____	

Treatment to date: <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Chiropractic <input type="checkbox"/> Osteopathy <input type="checkbox"/> Other: _____	
Treating doctor:	
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"/>	