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:

Claim number: _____
Organisation: _____
Claim Manager: _____
Tel: _____
Fax: _____
Postal Address: _____
_____

Approval given for:

Initial Assessment ☐
Full Program ☐
Approval request ☐

Client details:

Name: _____
Surname: _____
DOB: _____
DOI: _____
Address: _____
Tel: _____
Mobile: _____

Employment details:

Occupation: _____
Employer: _____
Contact Person: _____
Position: _____
Phone: _____
Fax: _____
Email: _____

Rehabilitation Goal:

Pre-injury duties ☐ Redeploy ☐ Improve injury self-management ☐

Comments:

_____
_____

Diagnosis:

Nature of injury/ diagnosis: _____
_____

Treatment to date: ☐ Physiotherapy ☐ Chiropractic ☐ Osteopathy ☐ Other:_____

Treating doctor:

GP name:_____ Address or surgery stamp:_____
Tel:_____ _____
Fax:_____ _____

GP is aware that patient will be attending program Yes ☐ No ☐