Occupational Focus
Occupational Therapy & Injury Management Consulting
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REFERRAL FORM – INCOME PROTECTION & LIFE INSURANCE SERVICES

CLIENT DETAILS

Name:		
Address:		
Telephone:	Work:	Mobile:
Date of Birth:		Date of Injury:
Diagnosis / Type of Injury:		
Medical Restrictions (as per med cert):		
Occupation:		
Interpreter Required: Yes / No		Language:

Please attach copies of any relevant reports/information to this referral form.

AGENT / INSURER

Agent/Insurer:	
Contact Person:	Position:
Telephone:	Fax:
Email:	
Address:	
Claim Number:	Liability Accepted: Yes / No / Don't know

EMPLOYMENT INFORMATION

Employer:	Contact Person:
Address:	
Telephone:	Email:
At Work: Yes / No	Date Ceased Work:

TREATING DOCTOR

Name:	Telephone:
Address:	
Email:	Fax:

REASON FOR REFERRAL

☐ Initial Needs Assessment	☐ Workplace Assessment
☐ Ergonomic Assessment	☐ Case Management
☐ ADL Assessment	☐ Medical Case Conference
☐ Home Assessment	☐ Driver Assessment & Rehabilitation
☐ TPD ADL Assessment	☐ Pre-Disability Work Duties Assessment
☐ Other (Please Specify):	

REFERRER TO COMPLETE

Payment Classification codes to be used:	
No of Hours Approved:	
Signature:	Date:
Name:	Title:

By sending this referral the referrer acknowledges that any work completed will incur costs for services provided, and the referrer has the relevant authority and approval to refer for requested services.