navigate health

www.navhealth.com.au
PO Box 7016 Redhead NSW 2290

REFERRAL FOR SERVICES

Worker / Client Details

Worker name:		**Date of birth:**	
Address:			
Mobile:		**Email:**	
Date of injury:		**Claim number:**	
Current work status / RTW goal:	Fit for pre-injury work To be confirmed		

SERVICES REQUESTED:

☐ Initial RTW Services – (Workplace Assessment, Development of RTW plan, Medical Case Conference)
☐ RTW services – Same Employer
☐ RTW Services – New Employer
☐ Workplace Assessment
☐ Functional Capacity Assessment
☐ Ergonomic Assessment
☐ Vocational Assessment
☐ Complex Case Management
☐ Medical Case Conference
☐ Activities of Daily Living Assessment
☐ Other: _____

Referrer Details and Declaration

Referrer name:		**Role / organisation:**	
Phone:		**Email:**	
Relationship to worker:	☐ Treating GP ☐ Treating Therapist ☐ Worker/self-referral ☐ Employer ☐ Insurer ☐ Other: _____		
Declaration:	I confirm that I am requesting the services identified in this referral and have provided information that is accurate to the best of my knowledge. Where required, I have discussed this referral with the worker and relevant parties.		
Referrer signature:		**Date:**	

Worker Agreement

Has the worker been advised of this referral, and is the worker in agreement with this referral? ☐ Yes ☐ No			
If no, please provide reason or relevant context:			
Worker name:		**Worker signature:**	
Date:		**Preferred contact:**	☐ Phone ☐ Email ☐ SMS

Injury and Treatment Details

Diagnosis / injury details:			
General Practitioner:		**Phone:**	
Allied health provider:		**Phone:**	
Specialist:		**Phone:**	

Employer Details

Employer:		**Phone:**	
Address:			
Employer contact:		**Role:**	
Email:			

Insurer Details

Insurer:	EML	**Case manager:**	
Phone:		**Email:**	
Has insurer approval been obtained, if required?	☐ Yes ☐ No ☐ Not applicable / to be confirmed		