

REFERRAL FORM

CLIENT DETAILS

Name Mr/Mrs/Ms: _____ D.O.B.: _____
 Address: _____
 Phone (H): _____ (W): _____ (M): _____
 Occupation: _____ Area Injured: _____ D.O.I.: _____
 Non-English Speaking Interpreter required Yes No Language: _____

INSURANCE COMPANY

Company: _____ W/C CTP Claim No.: _____
 Claims Manager: _____ Ph: _____
 Postal Address: _____ Fax: _____

NOMINATED TREATING DOCTOR

Name: _____ Ph: _____
 Practice Name: _____ Fax: _____
 Address: _____
 Gym Lifting Restriction 5kg 10kg 15kg 20kg
 Please forward a Referral Pad: Doctors Signature: _____

REHABILITATION PROVIDER

Company Name: _____ Ph: _____
 Case Manager: _____ Fax: _____
 Postal Address: _____

EMPLOYER

Company Name: _____ OHS Officer: _____
 Address: _____ Ph: _____

WORK STATUS

Working: Yes No PID SD Hours: _____ Days: _____ Restrictions: _____
 Rehabilitation Goal: _____

SERVICES REQUESTED

Physiotherapy Services

- Acute and Manual Therapy
- Initial Assessment & Report
- Functional/Work Related Activity Treatment
- Education (Advice/ Reassurance)
- Case Conference
- Workplace Visit

Psychology Services

- Initial Assessment & Report
- Pain Management/CBT
- Posttraumatic Stress Disorder
- Anxiety, Depression
- Medicare Benefits Scheme

Preventative Services

- Manual Handling Education
- Worksite Exercise Programs
- Please forward a Referral Pad

REFERRED BY

Name: _____ Date: _____
 Company: _____ Ph: _____
 Address: _____ Fax: _____
 Special requests: _____

GYM LOCATIONS

Bankstown | Blacktown | Burwood | Campbelltown | Cherrybrook | Crows Nest | Fairfield | Five Dock | Hurstville | Lewisham | Liverpool | Maroubra
 Marrickville | Merrylands | Neutral Bay | North Ryde | Orange | Parramatta | Penrith | Rockdale | St Leonards | St Marys | Surry Hills | Sutherland