COASTAL Work &RehabilitationSolutions

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Referral Form

The following services are requested (please tick):

- ☐ Initial Needs Assessment
- ☐ Work Wellness Assessment (Mental Health)
- ☐ Workplace Assessment
- ☐ Ergonomic / Workstation Assessment
- ☐ Vocational Assessment
- ☐ Vocational Counselling
- ☐ Other:
- ☐ Pain Management Assessment
- ☐ COVID-19 Wellbeing Program
- ☐ Suitable Duties Program
- ☐ Physiotherapy Assessment
- ☐ Functional Capacity Assessment
- ☐ Activities of Daily Living Assessment

Claimant / Injured Worker Details

Name:		Claim No:	
Address:			
Telephone:		Date of Birth:	
Job Title:		Pre-Injury Hrs:	
☐ At Work	☐ Working partial hours (No. of Hours):	☐ Not at Work	

Injury / Diagnosis Details

Nature of Disability/ Injury:	
Additional Information	
Date of Injury:	
Current Medical Certification:	

Additional Information

Insurer Details

Insurer:		Claim No:	
Insurer Contact:			
Email / Phone:			

Treating Provider Details

Treating Practitioner:	
Address:	
Email / Phone:	

Treating Specialist:	
Address:	
Email / Phone:	

Physiotherapist:	
Address:	
Email / Phone:	

Other:	
Address:	
Email / Phone:	

Referrer Details

Name:		Phone:	
Agency:		Email:	
Role:		Date:	

Reporting / Invoicing

Do you require a report:	☐ Yes ☐ No
Reports Attached:	☐ Medical Certificate ☐ Specialist Report ☐ Medical Investigation Reports ☐ Other:
Invoice addressed to:	

Please forward this referral form to CWRS via email to admin@cwrs.com.au