WORKLIFE

DONNELLY AYRES

A DIVISION OF KRINSKY PTY LTD
ACN 005 556 409 ABN 11 005 556 409

Request for Occupational Rehabilitation Services

Client Name: ______________________ Provider Ref: _________________ Claim Number: _____________

Address: ____

Telephone No: ______________________ Date of Birth: ____/____/____ Injury Date: ____/____/____

Name of Injury: ______________________________ Occupation: ______________________________

At work, same pre-injury jobs: ☐ At work, less pre-injury: ☐ Not at work: ☐

Interpreter: Yes ☐ No ☐ Language: ______________________________________

Employer Details (if applicable)

Employer Name: _________________________________ Contact: ___________________________

Address: ____

Telephone No: __________________________ Fax No: _______________________________

Service Requested: ____

Treating Health Practitioner Details

Doctor's Name ____

Address: ____

Telephone No: __________________________ Fax No: _______________________________

Services Requested

Expected Outcomes	Codes	Hours	Cost (inc GST)

WISE Eligible: Yes ☐ No ☐ Not Applicable ☐

Proposed Start Date: ____/____/____ Proposed End Date: _____/_____/_____

Total Cost including GST Agreed $_______________

Employer / Provider Approval

Liability is accepted and approval granted for the agreed occupational rehabilitation services to commence.

Employer: ______________________________ Insurer: ____________________________

Employer Rep: ______________________________ Insurer Rep: ____________________________

Title: ______________________________ Title: ____________________________

Signature: ______________________________ Signature: ____________________________

Date: _____/_____/_____ Date: _____/_____/_____