

CLAIMS ADVISORY AND RETURN TO WORK REFERRAL FORM

REFERRAL DETAILS						
Referral name				Referral surname		
Direct phone				Date referred	day	month
					year	
EMPLOYEE DETAILS						
Organisation						
First name				Surname		
Position / role				Direct phone		
Mobile				Home phone		
Email address				Date of birth	day	month
					year	
Postal address						
Claim / reference no.						
Date of incident	day	month	year			
Nature of injury						
Worker occupation						

Type of job	<i>Full time</i>	<i>Part time</i>	<i>Casual</i>			
Average earnings per week	\$		Average hours worked per week			
Work status code			Date ceased work	day	month	year

TREATING DOCTOR

Organisation					
First name			Surname		
Direct phone			Facsimile		
Postal address					

EMPLOYER DETAILS

Organisation					
First name			Surname		
Direct phone			Email address		
Postal address					
Supervisor first name			Supervisor surname		
Direct phone			Email address		

INSURER DETAILS				
Organisation				
First name		Surname		
Direct phone		Email address		
Postal address				
Please indicate the supporting material you will supply. NOTE: Once you <i>submit</i> this referral form you will be prompted to attach your supporting material to an email, which will be sent to Worksite.				
Attachments	Medical certificates	Medical reports	X-Ray / MRI reports	Other
Any other comments				
SERVICES REQUIRED				
Advice following initial reporting of injury	Auditing of existing claims	Calculation of entitlements to workers compensation	Case Conferencing with relevant parties	Claim estimate reviews
Claims review with the Insurer	Completion of lodgement of necessary forms	Identification of complex/long term claims	Implementation of return to work plans	Implementation of workplace Anti-Bullying Policy
Interpreter/ translating services	Liaisons with brokers/insurer	Mediation	Monitoring of return to work process	OHS training
Premium reviews	Recommendation of prevention of workplace injuries	Recommendation on best approaches to Injury Management	Status check	



<i>Other</i>	
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PLEASE HIT THE SUBMIT BUTTON BELOW TO EMAIL THIS FORM, ALONG WITH ANY OTHER SUPPORTING INFORMATION TO info@worksite.net.au OR SEND VIA FAX ON 02 9807 7199 INCLUDING YOUR CLAIM REFERENCE NUMBER