

REFERRAL FORM

VOCATIONAL REHABILITATION (VR1)

Provider Name: _____	Provider No: _____
1 Worker's Name: _____	
Mr/Mrs/Miss/Ms	Surname
Date of Birth: __ / __ / ____	Telephone No. _____
DD / MM / YYYY	
Claim Number: _____	
Insurer: _____	Contact: _____
Date of Injury: __ / __ / ____	
DD / MM / YYYY	
Injury Type: _____	Occupation: _____
Worker's Address: _____	Postcode: _____
2 Referring Source:	
<input type="checkbox"/> Treating Medical Practitioner <input type="checkbox"/> Employer <input type="checkbox"/> Conciliation and Review <input type="checkbox"/> Insurer on behalf of Employer (authority attached)	
3 Referral Type: Please Tick	
<input type="checkbox"/> Vocational Rehabilitation Assessment (Medical practitioners and employers must always consult with each other and the worker prior to the referral) I HAVE DISCUSSED THIS REFERRAL WITH: <input type="checkbox"/> Employer OR <input type="checkbox"/> Treating Medical Practitioner (If repeated attempts at containing the other party have been unsuccessful, please contact the Rehabilitation Review Unit at WorkCover WA on 1300 794 744.)	<input type="checkbox"/> Specific Service: (please indicate) <input type="checkbox"/> Functional Capacity Evaluation <input type="checkbox"/> Job Analysis <input type="checkbox"/> Manual Handling/Work Technique Advice <input type="checkbox"/> Worksite Assessment Other: _____
or	
<input type="checkbox"/> I have discussed this referral with the worker and they are in agreement.	
Referrer's Signature: _____	Date: __ / __ / ____
DD / MM / YYYY	
4 Employer Details: Company Name: _____	
Contact Name: _____	Telephone: _____
Surname	Other Name(s)
Address: _____	Postcode: _____
Treating Medical Practitioner Details: Dr's Name: _____	
Surname	
Other Name(s)	
Street: _____	Suburb: _____
State: _____	
Telephone: _____	Practice Name: _____
Postcode: _____	
5 Section to be completed by Vocational Rehabilitation Provider:	
Has a vocational programme previously been undertaken with you or another provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Worker's last Recurrence: __ / __ / ____
DD / MM / YYYY	
Referral Type: <input type="checkbox"/> Vocational Assessment	<input type="checkbox"/> Specific Service
Date referral received: __ / __ / ____	
DD / MM / YYYY	
Did this current referral period proceed to assessment/specific services? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, please indicate: <input type="checkbox"/> 1st Schedule Redemption <input type="checkbox"/> 2nd Schedule Settlement <input type="checkbox"/> Common Law Election	
<input type="checkbox"/> Other: _____	Costs Incurred: _____
Rehabilitation Provider: Please submit to WorkCover WA within 5 working days and retain copy on worker's file	