REFERRAL FORM
Work Conditioning / Exercise Physiology

UNSW MEDICINE
Lifestyle Clinic

CLIENT DETAILS

Name: _____ DOB: _____

Address: _____ Postcode: _____

Phone: (H) _____ (M) _____ (W) _____

Email: _____ Occupation: _____

Gender: M / F Interpreter Required: ❑ No ❑ Yes Language: _____

EMPLOYER / INSURER / REHAB PROVIDER DETAILS

Claim No. _____

Employer: _____ Contact person: _____

Phone: _____ Fax: _____ Email: _____

Insurer: _____ Contact person: _____

Phone: _____ Fax: _____ Email: _____

Rehab Provider: _____ Contact person: _____

Phone: _____ Fax: _____ Email: _____

TREATING DOCTOR

Doctor Name: _____

Address: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

INJURY DETAILS

Currently At Work: ❑ Yes ❑ No

Date of injury: _____ Diagnosis: _____

_____

Rehabilitation goals: _____

_____

REFFERAL DETAILS

Referral submitted by (name): _____ Phone: _____

Have you notified the Nominated Treating Doctor (NTD) of this referral ? ❑ Yes ❑ No

Costs accepted for initial assessment: ❑ Yes ❑ No

SERVICES REQUESTED *(Note: WorkCover-NSW Service Item Codes listed with each service below)*

❑ Initial (Pre-Intervention) Assessment & Report (EPA 001 & EPA 007)
❑ Initial (Pre-Intervention) Assessment only (EPA 001)
❑ Functional Conditioning / Work Conditioning (EPA 002)
❑ Active-Based Therapy / Exercise Rehabilitation (EPA 002)
❑ Post-Intervention Report (EPA 007)

PLEASE FAX THE COMPLETED REFERRAL FORM TO (02) 9385 3195.

(Where available, please include copies of all relevant medical and treatment provider reports, RTW plans and workplace assessment reports with this referral.)

UNSW MEDICINE LIFESTYLE CLINIC ABN 57 195 873 179
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