Provider No: 660
P: 0407 006 182
F: 02 4006 3081
E: bgrills@iandmi.com.au
www.iandmi.com.au

WORKPLACE REHABILITATION REFERRAL FORM

Personal Details	
Surname:	Mr/Ms/Miss/Mrs
First Name(s):	
Date of Birth:	Age:
Address:	
	Postcode:
Phone No.:	
Mobile No.:	
Interpreter Required:	Yes/No Language:
Occupation:	

Employer Details	
Employer:	
Rehab Coordinator:	
Address:	
	Postcode:
Phone No.:	
Fax No.:	

Insurer Details	
Insurer:	
Claim No.:	
Claims Officer:	
Rehab Advisor:	
Address:	
	Postcode:
Phone No.:	
Fax No.:	
Email:	

Injury Details	
Date of Injury:	
Cause of Injury:	
Type of Injury(s):	

Union	
Union:	
Contact Name:	
Phone/Fax:	

Treating Doctor/Specialist	
Doctor's Name:	
Address:	
	Postcode:
Phone/Fax:	
Specialist's Name:	
Address:	
	Postcode:
Phone/Fax:	

Reason for Referral

I, _____ wish to
Print Name
nominate Injury and Mediation Interventions as my nominated rehabilitation provider:

_____ _____
Signature Date

Referred by: ☐ Self ☐Employer ☐Insurer ☐Union

Approval for Injury Management Services

Liability accepted: ☐ Yes ☐ No Previous Rehabilitation: ☐ No ☐ Yes

Approval given to undertake workplace rehabilitation assessments

Name: ..... Date: .....

Signature: .....(Employer / Insurer)

Please return signed copy to Injury and Mediation Interventions Fax 024006 3081