PINNACLE
WORKPLACE CONSULTANTS

REFERRAL FORM - REHABILITATION SERVICE

Client information

Name:	Claim no.:
Address:	Date of birth:
	Telephone no:
Language used:	Interpreter needed: yes ☐ no ☐

Referral information

Date of referral:	
Referral source:	Telephone no:
General practitioner:	Telephone no:
Specialist:	Telephone no:

Injury details

Date of injury:
Diagnosis:
Injury details:

Employer information

Occupation:	
Employers name:	Telephone no:
Employers address:	
Rehab coord/supervisor:	Telephone no:

Billing details

Claims coordinator:	Telephone no:
Address:	

Report to be sent to

Service required

Worksite Assessment	☐	ADL	☐	Other ☐ _____	
Workstation Assessment	☐	Job Analysis	☐	Graduated Return to Work	☐
Job Dictionary	☐	Doctor's Letter	☐	Functional Matching Matrix	☐

Other Comments (*ie Reason For Referral, Medical Restrictions, Contra Indications)*

NAME _____ **SIGNATURE** _____ **DATE** _____