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VR1 – WORKPLACE REHABILITATION REFERRAL
Form 310

Provider name: STAR INJURY MANAGEMENT SERVICES | Provider number: 079

Please refer over for referral instructions and forward the form directly to the Provider.

1. Worker's name

Date of Birth | Telephone number

Claim number | Insurer | Date of injury

Injury type

Worker's address

2. Referring source

☐ Treating medical practitioner ☐ Employer ☐ Insurer on behalf of employer (authority attached)

3. Referral type

☐ **Workplace rehabilitation assessment** (Medical practitioners and employers must always consult with each other and the worker prior to the referral for rehabilitation assessment)

Specific service (please indicate) (See over for further description)

☐ Functional capacity assessment ☐ Job demands assessment

☐ Ergonomic assessment ☐ Workplace assessment

☐ Other

☐ I have discussed this referral with the worker and their ☐ **Employer** or ☐ **Treating medical practitioner** and they are in agreement.

Referrer's name | Referrer's signature | Date

4. Employer's details Company name

Contact name | Telephone

Address

Treating medical practitioner details

Practice name | Telephone

Address

5. Section to be completed by workplace rehabilitation provider

Has workplace rehabilitation programme previously been undertaken with you or another provider? ☐ Yes ☐ No

Interpreter required? ☐ Yes ☐ No Date of worker's last recurrence

Referral type ☐ Assessment ☐ Specific service

Date referral received | Did this current referral proceed to assessment/specific service? ☐ Yes ☐ No

If **No** please indicate ☐ 1st Schedule Redemption ☐ 2nd Schedule Redemption ☐ Common Law Election

Other | Costs incurred

Rehabilitation Provider: Please enter details into the Online Rehabilitation application within 28 days of receipt of referral and retain copy on worker's file.