AXIS
INJURY MANAGEMENT

REFERRAL FOR INJURY MANAGEMENT SERVICES

Provider Name: Axis Injury Management	**Fax to:** (02) 4927 1677

Worker: .... Claim No: .... D.O.B: ....
Phone: .... Address: ....
Type of Injury: .... Date of Injury: ....
Occupation: .... Work Location: ....

Employer: .... Phone: .... Fax: ....
Return to Work Coordinator: ....
Address: .... Postcode: ....

Insurer: .... Phone: .... Fax: ....
Contact: .... Claims Contact: ....
Address: .... Postcode: ....

Doctor: .... Phone: .... Fax: ....
Address: .... Postcode: ....

Treating Specialist: .... Phone: .... Fax: ....
Address:............................ Postcode: ....

☐ At Work ☐ Off Work (Ceased ___/___/___)

Interpreter Required ☐ Yes ☐ No Language: ....

☐ Initial rehabilitation assessment	☐ Workplace assessment
☐ Functional capacity assessment	☐ Psychological assessment / counselling
☐ Vocational assessment	☐ Medico-legal / Section 40 assessment
☐ Ergonomic / workstation assessment	☐ Other ....

Comments: ....
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Liability Accepted ☐ Yes ☐ No ☐ Don't Know

Comments: ....
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Approval is hereby given to undertake occupational rehabilitation services up to the development of a rehabilitation plan or as otherwise specified.

Signature .... Date ....

Name .... Title: ....