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Injury management consultant referral

NSW GOVERNMENT | State Insurance Regulatory Authority

Section 1: Worker

Name

Claim number

Date of birth (DD/MM/YYYY)

Date of injury (DD/MM/YYYY)

Mobile number

Diagnosis

Current work status (if no capacity for work, note the last day worked)

Occupation

Return to work or vocational goal

Section 2: Injury management consultant

Name

Street address (include unit/street/property/Lot or DP number if applicable – must not be a PO Box)

Suburb

State

Postcode

Contact number

Email

Section 3: Referral type

☐ Face to face consultation with worker

☐ File review

Worker wishes to be involved in discussions with the IMC?

☐ No ☐ Yes. If Yes, insurer to provide details of proposed arrangement for contact between IMC and worker

Section 4: Reason for referral

☐ The worker has been identified at risk of delayed recovery

☐ A specific return to work or injury management issue has been identified

Please provide explanation of the specific issue/s leading to the referral:

Referral has been requested by:

☐ Insurer ☐ Worker ☐ Employer ☐ NTD ☐ other treating practitioner

Section 5: Describe insurer actions to resolve the issue

Additional relevant background information

Section 6: Parties to contact

Nominated treating doctor (**must** contact)

Name

Street address (include unit/street/property/Lot or DP number if applicable – must not be a PO Box)

Suburb State Postcode

Contact number Email

Best time and day to contact (if known)

Employer (if relevant)

Name of employer

Contact person

Street address (include unit/street/property/Lot or DP number if applicable – must not be a PO Box)

Suburb State Postcode

Contact number Email

Union (if relevant)

Name of union

Contact person

Street address (include unit/street/property/Lot or DP number if applicable – must not be a PO Box)

Suburb State Postcode

Contact number Email

Treatment practitioner or workplace rehabilitation provider (if relevant)

Name

Profession

Street address (include unit/street/property/Lot or DP number if applicable – must not be a PO Box)

Suburb State Postcode

Contact number Email

Section 7: Insurer notification of referral

The insurer has informed the worker of the injury management consultant referral?

☐ Yes ☐ No

The insurer has informed the nominated treating doctor of the injury management consultant referral

☐ Yes ☐ No

If 'No' to either, please provide reasons:

Section 8: Insurer details

Name

Title

Insurer

Name

Claim number

Direct phone number

Email

Best time and day to contact

Date of referral (DD/MM/YYYY)

Section 9: Documentation attached

- ☐ Certificates of capacity
- ☐ Last 2 Allied health recovery requests (if relevant)
- ☐ Recent imaging reports (if applicable)
- ☐ Claim form (if applicable)
- ☐ Relevant reports from Nominated Treating Doctor/Treating Specialist/Independent Medical Examiner
- ☐ Workplace rehabilitation provider reports
- ☐ Medication list
- ☐ Return to work plans
- ☐ Last 2 Injury management plans

Section 10: Additional relevant information

Catalogue No. SIRA09081
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