



**OutComes.
Referral Form.**

Please complete this with your Doctor
Fax the completed form to (03) 8677 1863

Patient Details

Patient's full name:

Date of Birth: Gender Male Female

Patient's address:

Patient's telephone number:

Employer Details

Employer's name:

Employer's address:

Injury details

Date of injury: Have you lodged a Work Cover claim? Yes No

Description of injury/disease:

Diagnosis:

Medical Practitioner identification

Medical Practitioner's name:

Practice address:

Practice telephone number:

Choice of rehabilitation provider

I, the undersigned, confirm that I have chosen Optimum Carer as my choice of rehabilitation provider and understand that they will provide services pertaining to my safe and productive return to work

Authority to obtain and release

I, the undersigned, authorise Optimum Career to obtain and release information regarding my injury/ condition from and to my treating practitioners, employer, WorkSafe agent and any other relevant parties.

Signature of patient

Date

Important notice for Medical Practitioners

When issuing the WorkCover certificate of capacity please complete the section "Referral to another healthcare provider" with "Optimum Career- Occupational Rehabilitation."

Thank you