

Note: The *Allied health provider guidelines for forms* are available from Q-COMP at www.qcomp.com.au or call 1300 789 881.

Date of assessment: _____

Date of referral: _____

Worker's details

Name: _____

Claim number: _____

Telephone: _____

Interpreter required? _____

Date of Birth: _____ Date of injury: _____

Yes No

Ceased work date: _____

Injury type: _____

Occupation at time of injury: _____

Provider's details

Name: _____

Telephone: _____

Address: _____

Fax: _____

Email: _____

Reasons for referral to job seeking initial consultation

Sources of medical information relied upon for this report (e.g. medical reports, providers)

Worker's injury condition (e.g. Medical restrictions)

Worker's perspective of factors impacting on return to work

Worker's literacy

Worker's current education/qualifications (schooling/certificates/licences/courses/qualifications)

Worker's employment history (Most recent first)

Job title	Employer	Duties	Employment period
1.			
2.			
3.			
4.			
5.			

Worker's job interests (Worker's perceived interests/skills/hobbies)

Transferable skills/abilities

Identification of suitable employment options

Worker's address:

Worker's access to transport:

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1. Occupational details	1. Labour market analysis
Job title:	
Duties:	
2. Occupational details	2. Labour market analysis
Job title:	
Duties:	
3. Occupational details	3. Labour market analysis
Job title:	
Duties:	
4. Occupational details	4. Labour market analysis
Job title:	
Duties:	

Additional information (as appropriate)

Providers signature: _____

Date: _____

Date submitted to Insurer _____