# Please forward referral to hello@ehgroup.au

**Ph: 0404104082** **VR1 Referral Form**

**Workplace rehabilitation provider: Enhance Health Group Pty Ltd**

## Details

| | | |
|---|---|---|
| **Name (Worker):** | **DOB:** | **Date of injury:** |
| **Claim number:** | **Phone:** | |
| **Address:** | **Email:** | |
| **Insurer:** | **Phone:** | |
| **Email:** | | |

## Referral

| | | |
|---|---|---|
| ☐ **Specific service** | ☐ Functional capacity<br>☐ Vocational<br>☐ Ergonomic | ☐ Job demands<br>☐ Workplace<br>☐ Aids & appliances |
| ☐ **Rehabilitation program** | | |

## Status of worker

| | |
|---|---|
| ☐ Working / full capacity<br>☐ Working / partial capacity | ☐ Not working / full capacity<br>☐ Not working / partial capacity<br>☐ Not working / no capacity |

## Employer details

| | |
|---|---|
| **Company:** | |
| **Contact name:** | |
| **Address:** | **Phone:** |
| **Email:** | **Fax:** |

## Medical practitioner

| | |
|---|---|
| **Company:** | |
| **Name:** | |
| **Address:** | **Phone:** |
| **Email:** | **Fax:** |

## Source of referral

| | | | |
|---|---|---|---|
| ☐ Medical practitioner | ☐ Employer | ☐ Insurer | ☐ Worker/representative |

## Referrer

| |
|---|
| **Signature:** |
| **Name:** |
| **Date:** |

**Insurer –** Submit referral into WorkCover WA Online
**Employer, medical practitioner and worker –** Provide form to the insurer or WRP
**WRP –** Provide form to the insurer