



Your health care team.

12-22 Richmond Road Keswick SA 5035
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www.smarthealthtraining.com.au

Physiotherapy
Pilates
Massage
Chiropractic
Paediatrics
OH&S
Dietetics

REFERRAL FORM Please fax referral form to Smart Health on 8371 1577

CLIENT DETAILS	
NAME	DOB
CLAIM NUMBER	
ADDRESS	
PHONE NO <i>Hm:</i>	<i>mob:</i>
INJURY	
SECONDARY CONDITIONS	
1. 2. 3. 4.	
TYPE OF CLAIM	
<input type="checkbox"/> Workcover <input type="checkbox"/> Self insured employer <input type="checkbox"/> MVA <input type="checkbox"/> Personal injury <input type="checkbox"/> Military compensation <input type="checkbox"/> Other	

EMPLOYER DETAILS	
EMPLOYER NAME	
CONTACT PERSON	
PHONE NUMBER	
ADDRESS	

MEDICAL PRACTITIONER

NAME

PHONE NUMBER

ADDRESS

REFERRER DETAILS

NAME/COMPANY/SOLICITOR

CONTACT PERSON/PA CONTACT (FOR ADMIN PURPOSES)

PHONE NUMBER

OFFICE ADDRESS

BILLING ADDRESS (if different)

ASSESSMENT REQUEST

- FUNCTIONAL CAPACITY EVALUATION
 - VIDEO JOB ANALYSIS
 - INDEPENDENT CLINICAL PHYSIOTHERAPY ASSESSMENT
 - WORKSITE ASSESSMENT
-

Has GP Approval been gained:

 YES NO

Client Authorities completed and included:

 YES NO

Has this client shown any evidence of violent behaviours, personality disorders, resentment towards medical practitioners or any other condition that could potentially place Smart Health evaluators in danger of physical violence?

 YES NO

Does your client require an interpreter?

 YES NO**PAYMENT TERMS**

The account for this assessment is the responsibility of the referrer, and must be paid within 90 days of receipt of the associated report. In the case that the assessment and report are related to an active damages claim through an insurer, Smart Health will actively pursue payment from the insurer during that 90-day period. However, in the instance that the insurer refuses payment during this period, payment will be required by the referrer within 90 days. At the end of the 90 days should the insurer refuse to pay we will issue another invoice to the referrer to which payment will be required within 30 days.

Signature _____

Date _____