REFERRAL FORM

Plus Social for Injured Workers Program

Plus Social
Empowering individuals, building communities

This is a program designed to link injured workers to social activity groups and supports.
It is not a rehabilitation or return to work program.

REFERRER DETAILS			**Date of referral**
First name		Last name	
Practice/Organisation			
Address			
Phone No.		Email address	

TREATING DOCTOR DETAILS (only complete this section if the treating doctor is different to the referrer)			
First name		Last name	
Phone number		Email address	

INJURED WORKER DETAILS			**Claim number**
First name		Last name	
Date of birth		Gender	☐ Male ☐ Female ☐ Other
Address			
Phone number		Email	

ELIGIBILITY CRITERIA

1) ☐ Yes, the person is an injured worker for the purposes of the NSW Workers Compensation Scheme (i.e. is unable to return to work or has returned to work on reduced hours) (Exclusion: workers expected to return to work full-time within two (2) weeks)
2) ☐ Yes, Certificate of Capacity is attached
3) ☐ Yes, the person could benefit from increased social participation and linking to services that aim to meet their practical, social and wellbeing needs (e.g. social groups, meditation, yoga, art classes, tai chi, singing groups, financial counselling, housing assistance)
4) ☐ Yes, the person has consented to referral to the Plus Social program

Key issues identified (e.g. psychological wellbeing, finances, isolation) and / or any comments or considerations which may affect participation in group activities:	**Person areas of interest (e.g. photography, gardening)**

ADDITIONAL INJURED WORKER INFORMATION				
Country of birth			Main language spoken at home?	
Aboriginal	☐ YES ☐ NO	*(If needed- tick both)*	Communication support required?	☐ YES ☐ NO
Torres Strait Islander	☐ YES ☐ NO		Details, please specify.	
Are there any risk factors we should be aware of when visiting the home/person?	☐ NO ☐ YES - please specify or attach existing risk assessment if available			
Employment status	☐ Attached to employer ☐ Detached from employer ☐ Section 39 ☐ Return to work on light duties			
Certificate of Capacity	☐ YES (The referral must have a current Certificate of Capacity attached.)			

OFFICE USE ONLY Date: ☐ Accepted ☐ Referral not accepted, reason: Enter reason here

RETURN REFERRAL TO: **HealthLink** EDI: **gpsocial** or email: **nswintake@pccs.org.au**
Fax: **1300 067 747** or Phone: **(02) 9477 8700**