

REFERRAL FORM

Plus Social Program for People Injured at Work

This is a program designed to link people with a work related injury to social activity groups and supports.
It is not a rehabilitation or return to work program.

REFERRER DETAILS

First name			Last name			Date of referral	
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		

PERSON BEING REFERRED

First name			Last name			Claim number	
Date of birth			Gender			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
Address							
Phone number				Email			

ELIGIBILITY CRITERIA

- ☐ Yes, the person has been injured at work 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)
- ☐ Yes, Certificate of Capacity is attached
- ☐ 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)
- ☐ Yes, the person has consented to referral to the Plus Social program

Key issues identified (eg psychological wellbeing, finances, isolation) and / or any comments or considerations which may affect participation in group activities:	Person areas of interest (eg photography, gardening)
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ADDITIONAL INFORMATION ABOUT THE REFEREE

Country of birth		Main language spoken at home?	
Aboriginal	<input type="checkbox"/> YES <input type="checkbox"/> NO	(If needed - tick both)	Communication support required? <input type="checkbox"/> YES <input type="checkbox"/> NO
Torres Strait Islander	<input type="checkbox"/> YES <input type="checkbox"/> NO		Details, please specify.
Any risk factors we should be aware of when visiting the home/person?		<input type="checkbox"/> NO <input type="checkbox"/> YES - please specify or attach existing risk assessment if available	
Employment status	<input type="checkbox"/> Attached to employer <input type="checkbox"/> Detached from employer <input type="checkbox"/> Section 39 <input type="checkbox"/> Return to work on light duties		
Certificate of Capacity	<input type="checkbox"/> 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**