Cuff Link Service
Referral Form

Please send the completed referral form to cufflink@lifecare.com.au
If you have any questions, please contact us on 08 6332 6618 or 08 6332 6616, or email cufflink@lifecare.com.au

Worker's full name:		**Worker's phone:**	
Worker's email:		**Worker's address:**	
Date of birth:		**Date of injury:**	
Gender:		**Condition/injury:**	
Employer company:		**Pre-injury role:**	
Employer contact:		**Employer phone:**	
Insurance company:		**Claim number:**	
Insurance contact:		**Insurance phone:**	
Treating GP:		**GP clinic address:**	
Reason for referral/ additional Information:			

○ Cuff Link Service

- A comprehensive physical and functional review completed by a senior physiotherapist at a Lifecare clinic
- A succinct report summarising the injured person's presentation, functional ability, and recommended work capacity
- The recommended treatment plan/pathway

Optional services

Konekt

- ○ Workplace Assessment (specific service) and Return to Work Plan – if employer doesn't have a Job Task Analysis.
- ○ Rehabilitation Program (full workplace rehabilitation) – if ongoing return to work support is needed.

Occupational physician

- ○ A work capacity review with an occupational physician after the senior physiotherapist review, to issue a Workcover WA medical certificate and review/approve a Return to Work Plan. After the review, the occupational physician will contact the worker's nominated treating doctor (if one has been appointed) to discuss their recommendations post-review.

Referral attachment checklist

- ○ Most recent/first Workcover medical certificate
- ○ Any available medical imaging
- ○ A Functional Job Role/Task Analysis from the employer (if available)
- ○ Workplace Rehabilitation Referral Form
  (if a Workplace Assessment/Return to Work Plan or Full Workplace Rehabilitation is required)

Referrer details

Name:			
Position/job title:		**Company:**	
Telephone:		**Email:**	
Signature:		**Date:**	

The Cuff Link Service is delivered in partnership with Konekt, Lifecare, Prof Allan Wang and Dr Tareq Batanony.

GOVERNMENT OF WESTERN AUSTRALIA | WorkCoverWA

WORKPLACE REHABILITATION REFERRAL

Workplace rehabilitation provider:

DETAILS

Worker name: | Date of birth:

Claim number: | Date of injury:

Address:

Email:

Phone number: | Insurer:

REFERRAL

☐ **Specific service (*select which applies*)**

☐ Functional capacity ☐ Vocational ☐ Workplace

☐ Job demands ☐ Ergonomic ☐ Aids & Appliances

☐ **Rehabilitation program**

STATUS OF WORKER

☐ Not working / full capacity ☐ Working / full capacity

☐ Not working / partial capacity ☐ Working / partial capacity

☐ No working / no capacity

EMPLOYER DETAILS

Company:

Contact name: | Phone number:

Address:

Email: | ABN:

MEDICAL PRACTITIONER

Company:

Contact name: | Phone number:

Address:

Email:

SOURCE OF REFERRAL

☐ Medical practitioner ☐ Employer ☐ Insurer ☐ Worker / representative

REFERRER

Name: | Date:

Signature:

Employer, medical practitioner, and worker – provide form to the insurer or WRP.
WRP – provide form to the insurer.
Insurer – submit referral into WorkCover WA Online.