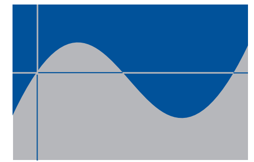
Job Ready Work Conditioning
Functional Exercise Rehabilitation

Bldg 13, University of Wollongong NSW 2522 Ph: 02 4221 3057 Fax 02 4221 5717



Referred by: Date:

Organisation: ______________________ Tel: (___) ______________________

Name: ______________________ Fax: (___) ______________________

Position: ______________________ Email: ______________@ ______________

Reason for the referral: Work - Conditioning ❑ De-conditioned ❑ Weight-loss ❑ Core Stability ❑

Area: Neck ❑ Back ❑ Shoulder ❑ Elbow ❑ Hand ❑ Hip ❑ Knee ❑ Ankle ❑ Other ❑

Diagnosis: ______________________

Account Details / Account to:

Claim Number: ______________________

Organisation: ______________________

Claim Manager: ______________________

Tel: (___) ______________________

Fax: (___) ______________________ Email: ______________@ ______________

Postal Address: ______________________ Suburb: ______________ Postcode: ______________

Approval given for:	**YES**	**NO**
Initial Assessment	❑	❑
Full Program	❑	❑
Job Ready to Request Approval	❑	❑

Client & Employer Details:

Surname: ______________________ Occupation: ______________________

Name(s): ______________________ Employer: ______________________

Date of Birth: ______________ Gender: MALE / FEMALE Contact Person: ______________________

DOI: ______________ Period off work ______________ Position: ______________________

Tel:H (___) ______________ Mob: ______________ Tel: (___) ______________ Fax: (___) ______________

Address: ______________________ Mob: ______________________

Suburb: ______________ Postcode: ______________ Email: ______________ @ ______________

Current Status at Work and Future Vocational Goals:

LIGHT Duties ❑ SUITABLE Duties ❑ RESTRICTED Duties ❑ Copy of Workcover certificate attached YES ❑ NO ❑

REHAB GOAL is to: Return to FULL Duties ❑ Re-DEPLOY to new area ❑ RETRAIN ❑ IMPROVE ADL's ❑

Comments: ______________________

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Treatment to Date

Treating Doctor: ______________________ Is aware that client will be attending Job Ready program ❑

Address or Place Surgery Stamp here: ______________________

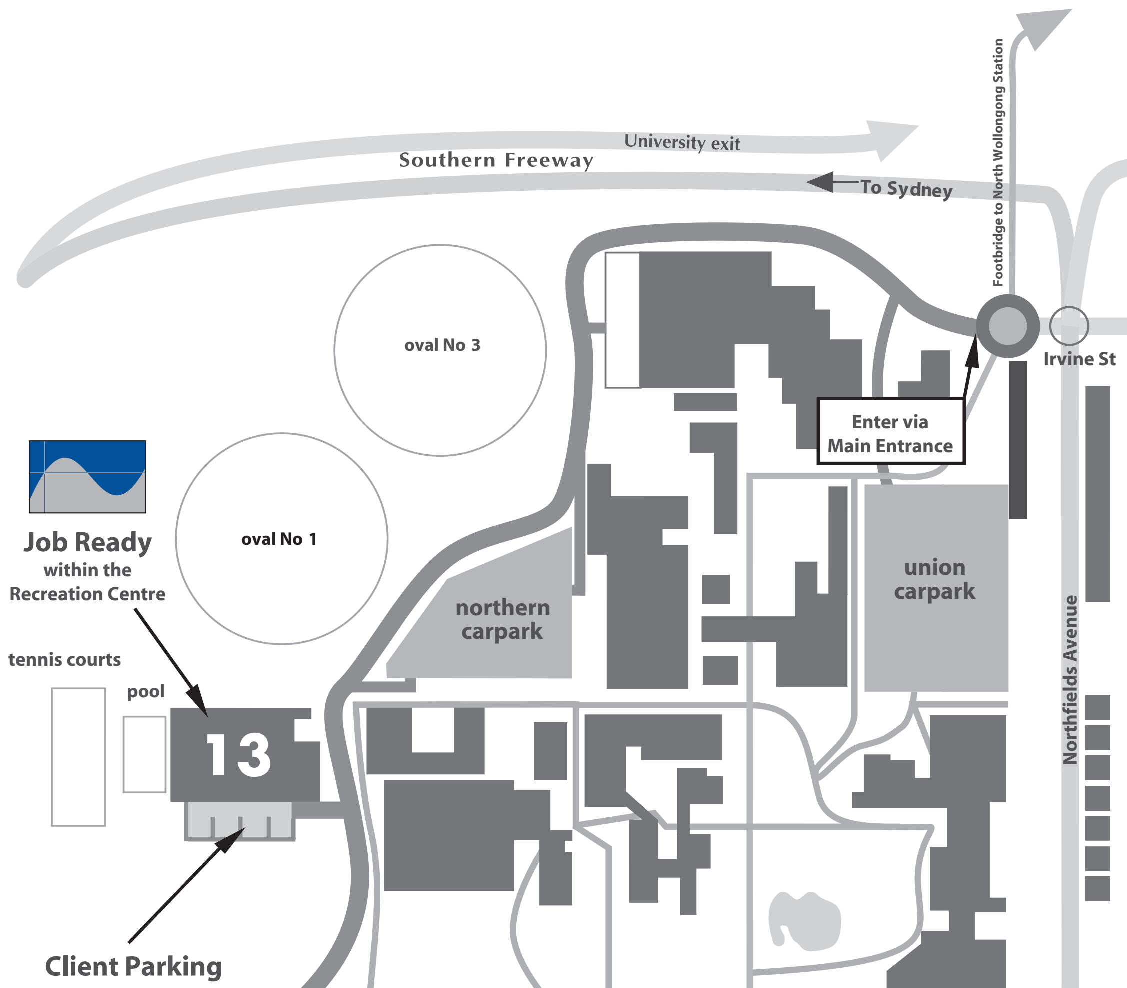
____

Tel : (___) ______________________ Fax: (___) ______________________

Print treating Doctor's Name: ______________________ Signature: ______________________

Physiotherapy ❑ Chiropractic ❑ Other: ______________________

I would prefer ongoing communications: ❑ by phone ❑ in writing



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Client Information

- Please call (02) 4221 3057 to confirm or make an appointment for your Initial Assessment
- Please arrive 15 minutes before your Initial Assessment
- Please wear loose clothing (exercise gear) and bring a towel
- Abstain from smoking and drinking coffee before the Initial Assessment
- Please bring copies of current Workcover Certificate, X-rays, MRI, CT scan reports, and any other relevant information pertaining to your current condition