



Clinical Psychologist
 Occupational Therapist
 Physiotherapists
 Exercise Physiologists
 Speech & Language Pathologist

TREATING DOCTOR REHABILITATION REFERRAL

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Referring Doctor:

Referring Doctor's Stamp



Patient Details

Patient Name: _____

DOB: _____

Patient Phone No: _____

Mobile: _____

Insurance Details:

<input type="checkbox"/>	Workers' Compensation
<input type="checkbox"/>	Private Health Fund
<input type="checkbox"/>	CTP / Other

Claim Number: _____

Diagnosis: _____

REHABILITATION & INJURY MANAGEMENT SERVICE

Multidisciplinary Program

- Work Hardening - Pain Management
- Work Hardening - Shoulder
- Work Hardening - Back

Specific Allied Health Service

- Rehabilitation (Initial) Needs Assessment
- Vocational Rehabilitation¹
- Home Assessment
- Disability Adjustment and Injury Counselling
- Physical Conditioning Program
- Speech Pathology

Specific Instructions: _____

Treating doctor's signature: _____

Date: _____

¹ Workplace evaluation, functional capacity evaluation, development of suitable duties program, vocational assessment, host employment placement, resume preparation, job seeking, interview skills, case management.

Thank you for the referral.