

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 email:

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:

Telephone:

Signature:

Company:

Email:

Date:

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.