

Referral Form		
Rehab Solutions PO Box 3503 Glastonbury Somerset BA6 8WQ Tel/Fax: 0845 643 6466 Email: clare.martin@rehabolutions.co.uk	For office use only	
	Date Assigned:	
	Case Manager:	
	Our Reference:	
	Code of Rehab Best Practice:	Y / N
	Joint Instruction:	Y / N
	Date Referred:	
Referrer Details:		
Company:	Estimated Value of claim: £	
Referrer Name:	Referrer Reference:	
Referrer Telephone:	Referrer Name:	
Referrer Fax:	Job Title:	
Insurance Company: (if different to referrer)	Address:	
Invoice to be sent to:	Insured:	
Claimant Details:		
Name:	Documents Provided (please list)	
Address:		
Date of Birth:		
Date of Injury:		
Occupation:		
Injury/Disability:		
Claimant Solicitor Details:		
Company Name:	Reasons for Instruction (please tick):	
Address:	Establish suitability for rehabilitation	
	Gain more information to help resolve claim	
	Case management of rehabilitation	
	Accelerate medical recovery	
	Assist with claimant's retraining	
Assist claimant's return to work		
Contact:	Other (please specify)	
Telephone:		
Reference:		
Specific Services Requested (please tick)		
Type of Coverage (please tick):		
Rehabilitation Assessment and Report	Employers liability:	
Telephone assessment and Report	Motor liability:	
Transferable Skills analysis	Public liability:	
Earnings Assessment	PHI:	
Employment & Voc Rehab Report for Court	Personal Accident	
Workplace stress assessment	Sickness/absenteeism:	
Other (please specify)	Other (please specify):	