rehabsolutions

Referral Form

Rehab Solutions
PO Box 72
Ventnor
Isle of Wight
PO38 9BE
Tel/Fax: 0845 643 6466
Email: info@rehabsolutions.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:	**Estimated Value of claim: £**
Company:	**Referrer Reference:**
Referrer Name:	Referrer Telephone:
Job Title:	Referrer Fax:
Address: Insured:	Insurance Company: (if different to referrer) Invoice to be sent to:

Claimant Details:

Name:	**Documents Provided (please list)**
Address:	
Date of Birth:	
Date of Injury:	
Occupation:	
Injury/Disability:	

Claimant Solicitor Details:	**Reasons for Instruction (please tick):**	
Company Name:	Establish suitability for rehabilitation	
Address:	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):	