MPOT/ACCESS FITNESS
SERVICES REFERRAL FORM

Referral Date: *

PART A – CLIENT INFORMATION * Required Information

Full Name: * Phone / Mobile: *

Address:

Email:

Date of Birth: * Occupation:

Private Health? ☐ Y ☐ N Concession? ☐ Y ☐ N

PART B – REFERRAL INFORMATION * Required Information

Referring Agency: *

Email:

Contact Name: * Contact No: *

Treating Doctor Details: including Address and Phone Number

Specialist Details: including Address and Phone Number

Diagnosis: Date of Disability:

PART C – SERVICE REQUIREMENT

(select one or more services required from the lists below):

Return To Work Services	Treatment / Assessment Services	Injury Prevention
☐ Rehabilitation & Return to Work Services ☐ Level 1 ☐ Level 2	☐ Physiotherapy	☐ Drug / Alcohol Screening ☐ Urine ☐ Saliva Swab
	☐ Exercise Physiology	
☐ Restoration to Community Rehabilitation	☐ Occupational Therapy	☐ Job Dictionary
☐ Suitable Employment Assessment	☐ Gym (Accessible)	☐ Ready to Work Assessment
☐ Fit for Work Service	☐ Hydrotherapy	☐ Pre-Employment Functional Assessment
☐ Worksite Assessment	☐ Functional Restoration Program	☐
☐ Job Analysis/ Ergonomic Assessment	☐ Work Conditioning Program	**Other Services**
☐ Functional Capacity Evaluation	☐ Activities of Daily Living Assessment	☐ External Case Management
☐ Independent Clinical Assessment	☐ Wheelchair & Seating Assessment **	☐ Drafting & Design Home Modifications
☐ List Other (below):	☐ Driver Assessment **	☐ Case Coordination
	☐ Speech Pathology	☐

** Complete Individual Referral Forms in addition to this form.

Additional Comments, Service Requests and Notes (below)**:**

PART D – EMPLOYER INFORMATION

Employer:		Contact No:	
Address:			
Email:			
Contact Name:			

PART E – INSURANCE INFORMATION

Insurer:		Claim Number:	
Address:			
Email:			
Contact Name:		Contact Number:	

WE RECOMMEND SAVING A COPY OF THIS FORM FOR YOUR OWN RECORDS.

PLEASE EMAIL COMPLETED FORM TO MPOT/ACCESS FITNESS: referrals@mpot.com.au