FIVEWAYS PHYSIOTHERAPY WORKCOVER CLAIMANT FORM

Mr Mrs Miss Ms Dr SURNAME: _____

GIVEN NAMES: _____ D.O.B: ___/___/___

PHONE: (H) _____ (W) _____ (MOB) _____

ADDRESS: _____

EMAIL: _____

EMPLOYER'S NAME:_____

EMPLOYER'S CONTACT NO:_____

REFERRING DOCTOR:_____

DATE OF INJURY:_____

DATES COVERED FOR TREATMENT:_____

HAVE YOU HAD ANY PREVIOUS PHYSIOTHERAPY TREATMENT FOR THIS INJURY? *(Please circle)*

YES NO

IF YES, PHYSIOTHERAPIST'S NAME:_____

HOW MANY TREATMENTS TO DATE?_____

WORKCOVER CLAIM NUMBER (IF KNOWN):_____

To ensure that WorkCover pays this account, please ensure that your employer has completed the necessary paperwork and that your treatments are within the specified dates as shown on your medical certificate.

Please also be aware that if you receive treatments outside this date, if your WorkCover Claim is ***rejected***, or you fail to present your medical certificates then the ***payment of this account becomes your responsibility.***

Signature:_____ **Date:** ____/____/____