

Medical Assessment Referral Form

Full Name:

Date of Birth:/...../..... Age:..... Handedness: R / L

Address:

Postcode:..... Contact phone:

Occupation (at time of injury):

Employer (at time of injury):

Duration of employment (at time of injury):..... Date of Accident/Injury.....

Claim Number: Insurer: EML / Gallagher Bassett / other.....

Case Manager: Return to Work Provider:

Type of Injury and/or Condition:

Interpreter: (where appropriate).....

General Information – Consent Form

Independent medical assessments such as this one may include such issues as permanent impairment assessment, causation, fitness for duty, rehabilitation, diagnosis, management and current status. This assessment is done with your consent, as per signature below.

The person requesting the assessment has asked for specific questions to be answered. In order to do this a relevant and comprehensive medical history and physical examination will be conducted.

Results of relevant special tests, investigations such as imaging studies (x-rays, ultrasounds, CT, MRI, etc) form part of the assessment. By signing this form you consent to Dr Byok obtaining results of special tests including imaging studies.

At the end of the examination Dr Byok will write a report answering questions from the referrer. By signing this form you acknowledge and consent to a report being sent.

Dr Byok is not your treating doctor and therefore it is not appropriate to ask her opinion or advice as she must remain independent.

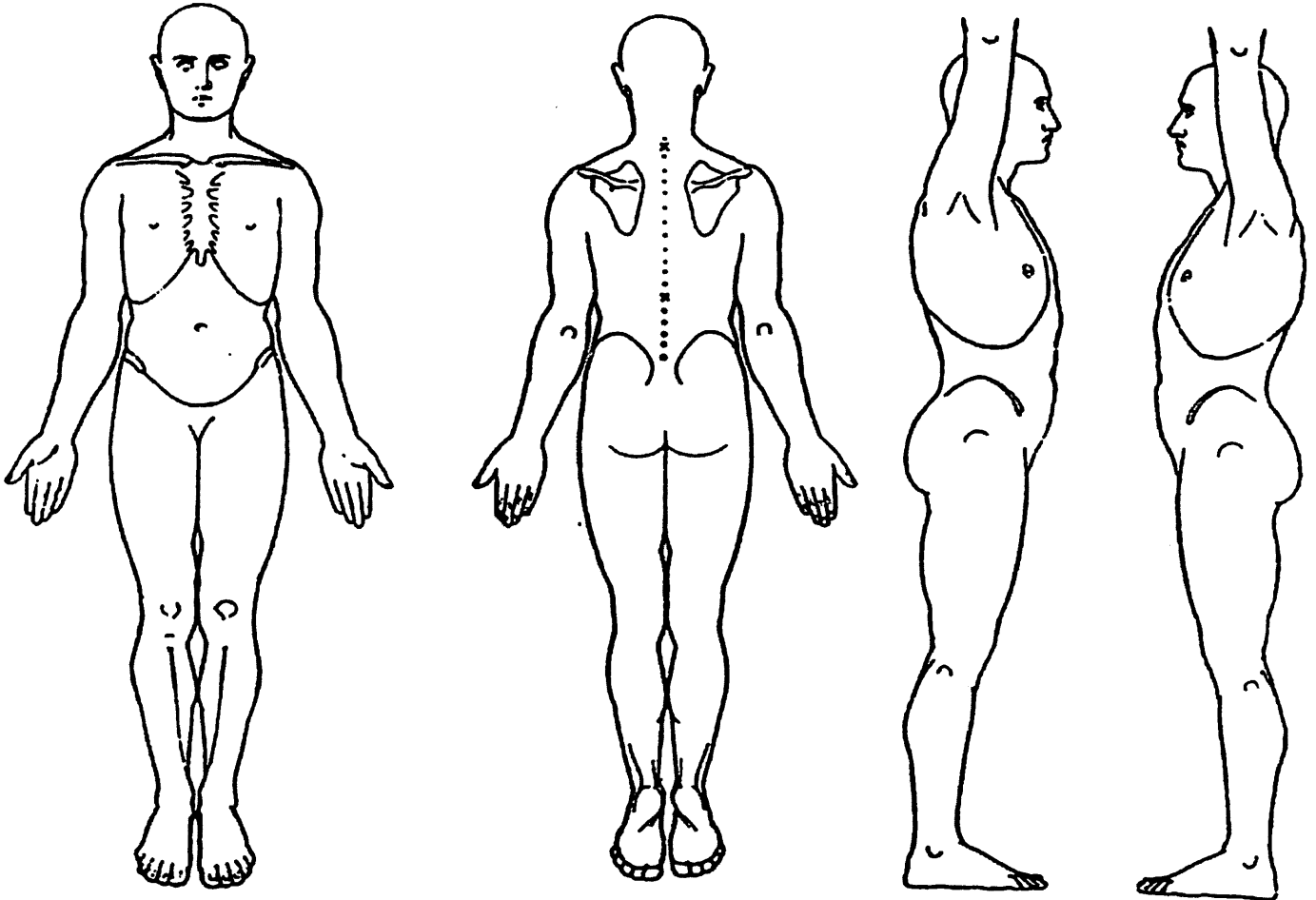
Information on the Privacy Act is available on the internet from www.privacy.gov.au.

Sign below to indicate that you have read and understood the above.

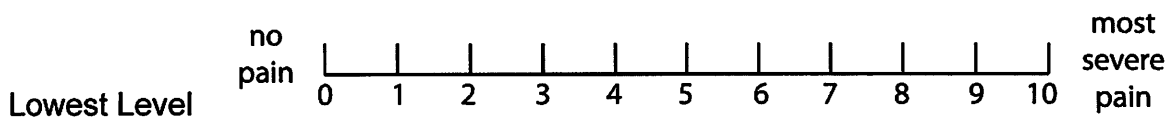
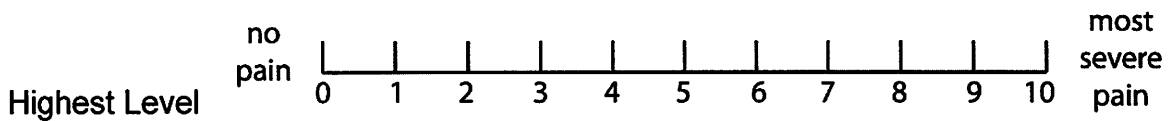
Signed

Date: / /

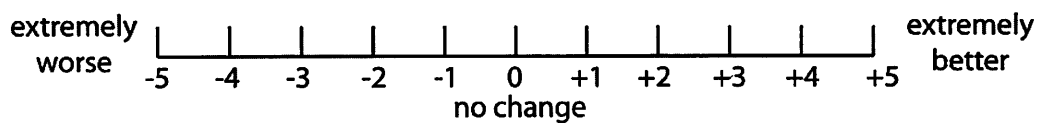
Please indicate on the diagrams below the areas where you are affected by pain.



In the pain score charts below please circle the number which best fits with your pain level over the last 2 weeks.



OVERALL IMPROVEMENT SINCE INJURY



NAME:

DATE: