Therapy for Life

PHYSIOTHERAPY

Treating ages: 0 - 120

Compensable Claim Details Form

Name: _____

I give permission for Therapy for Life to release medical information about myself and my treatment to the following agencies:

☐ Doctor Name:_____

☐ Claim Manager Name:_____

☐ Rehab Consultant Name:_____

Other:_____

_____

Doctors Referral Received: Y N Date: _____

Please provide us with the following details:

Employer at time of injury: _____ Phone: (____)_____

Insurance provider: _____ Claim number: _____

SA Insurer: ☐ Interstate Insurer: ☐

(Please note: Interstate claims will need to be paid in full and claimed back from your Insurance Provider.)

Claim manager: _____ Date of injury: ____/____/____

Referring Doctor: _____ Clinic: _____

Occupation title: _____

Pre-injury hours of work per week on average: _____ Post-injury hours per week:_____

Other comments: _____

Solicitors name and address: _____

Please note: if your Workcover or MVA claim becomes involved in legal proceedings, you must inform us immediately.

Signed: _____

Date: ____/____/____