|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *This is a program designed to link injured workers to social activity groups and supports.*  *It is not a rehabilitation or return to work program.* | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | ***Date of referral*** | Click/tap here |
| First name | Enter first name here | | | | | Last name | Enter last name here | |
| Practice/Organisation | Enter practice/organisation name here | | | | | | | |
| Address | Enter address here | | | | | | | |
| Phone No. | Enter phone number here | | | | | Email address | Enter email address here | |
| **TREATING DOCTOR DETAILS (only complete this section if the treating doctor is different to the referrer)** | | | | | | | | |
| First name | Enter first name here | | | | | Last name | Enter last name here | |
| Phone number | Enter phone number here | | | | | Email address | Enter email address here | |
| **INJURED WORKER DETAILS** | | | | | | | | |
| First name | Enter first name here | | | | | Last name | Enter last name here | |
| Date of birth | Enter date of birth here | | | | | Gender | Male  Female  Other | |
| Address | Enter address here | | | | | | | |
| Phone number | Enter phone number here | | | | | Email | Enter email address here | |
| **ELIGIBILITY CRITERIA** | | | | | | | | |
| 1. Yes, the person is an injured worker for the purposes of the NSW Workers Compensation Scheme (i.e. is unable to return to work or has returned to work on reduced hours) (Exclusion: workers expected to return to work full-time within two (2) weeks) 2. Yes, Certificate of Capacity is attached 3. Yes, the person could benefit from increased social participation and linking to services that aim to meet their practical, social and wellbeing needs (e.g. social groups, meditation, yoga, art classes, tai chi, singing groups, financial counselling, housing assistance) 4. Yes, the person has consented to referral to the Plus Social program  |  |  | | --- | --- | | **Key issues identified** (e.g. psychological wellbeing, finances, isolation) and / or any comments or considerations which may affect participation in group activities:  Enter key issues here | **Person areas of interest (e.g. photography, gardening)**  Enter areas of interest here | | | | | | | | | |
| **ADDITIONAL INJURED WORKER INFORMATION** | | | | | | | | |
| Country of birth | | Enter country of birth here | | | Main language spoken at home? | | Enter language here | |
| Aboriginal | | YES  NO | | *(If needed-tick both)* | Communication support required? | | YES  NO | |
| Torres Strait Islander | | YES  NO | | Details, please specify. | |  | |
| Are there any risk factors we should be aware of when visiting the home/person? | | | NO  YES - please specify or attach existing risk assessment if available | | | | | |
| Employment status | | Attached to employer  Detached from employer  Section 39  Return to work on light duties | | | | | | |
| Certificate of Capacity | | YES (The referral must have a current Certificate of Capacity attached.) | | | | | | |
|  | | | | | | | | |
| OFFICE USE ONLY Date: Click or tap to enter a date  Accepted  Referral not accepted, reason: Enter reason here | | | | | | | | |

**Please email this form to intake@pccs.org.au or fax to 1300 067 747.**

**Phone (02) 9477 8700 for further information.**

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*other support for this pilot program from the icare Foundation.*