**Agent case conference support service summary**

**Return to work assessment report**

1. **Claim details**

|  |  |  |  |
| --- | --- | --- | --- |
| Worker name |       | Claim number  |       |
| Worker date of birth |       | Date of injury |       |
| Referral date  |        | Report date |       |
| Injury  |       |
| Pre- injury employer |       |
| Claims agent |       | Case manager |       |
| Certifying medical practitioner |       |
| Weekly income maintenance at referral |       |

1. **Referral details**

|  |  |
| --- | --- |
| Purpose of referral  |       |
| Information requested by case manager |       |
| Method of obtaining information requested by case manager |       |

1. **List of key parties involved and role**

|  |  |  |
| --- | --- | --- |
| **Name**  | **Role & organisation** | **Date contacted/unavailable** (reason) |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |

1. **Items addressed & service activity**

|  |  |  |  |
| --- | --- | --- | --- |
| **Items** | **Agreed Action** | **By Whom?** | **By When?** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

1. **Service activity**

|  |
| --- |
|       |

Additional comments (where relevant):

Agent case conference report attached: YES / NO

1. **Return to Work Plan developed and attached** YES / NO

If no, provide reasons:

1. **Provider details**

|  |  |
| --- | --- |
| Consultant name |  |
| Title |  |
| Company |  |
| Address |  |
| Phone number |  |
| Email address |  |
| Signature: |  |
| Date: |  |