**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: |  |