**Vocational Assessment summary report**

**Return to work assessment service**

1. **Claim & referral details**

|  |  |  |  |
| --- | --- | --- | --- |
| Worker name |       | Claim number |       |
| Worker date of birth |       | Date of injury |       |
| Referral date |       | Report date |       |
| Injury |       | Certifying medical practitioner |       |
| Claims agent |       | Case manager |       |
| Certifying medical practitioner |       | Weekly income maintenance at referral |       |
| Worker’s current certified capacity and restrictions |       |

1. **List of Potential Suitable Employment options**

|  |  |  |  |
| --- | --- | --- | --- |
| **Job Title****(Attach person & job description)** | **Rates and award information** | **Sign off by certifying medical practitioner**YES / NO  | **Evidence attached**YES / NO |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |

1. **Assessment and supporting documentation**

Detail of psychometric assessments conducted (e.g. actual and potential ability, cognitive skills, aptitudes and competencies):

Suitable employment options

Labour market research details attached: YES / NO

If no, provide reasons:

Rates, and award information attached: YES / NO

If no, provide reasons:

Detail of discussions with medical practitioner to obtain agreement on suitable employment options:

1. **Recommendations**

Where applicable, details of training required to achieve suitable employment option:

Recommendations to address any barriers to worker achieving suitable employment goal:

Detailed Vocational assessment report attached? YES / NO

If no, provide reasons:

1. **Provider details**

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