Workers Compensation
Pre-consultation Questionnaire

All patients treated by this practice under the Worker's Compensation Scheme are required to complete this questionnaire prior to their appointment. The questions concern your work related injury. The primary purpose of this questionnaire is to assist in treating your injuries and making the best clinical decisions with all the information available.

Please ensure this form is completed in full. If you do not complete the information and return it prior to your appointment, we cannot proceed with your consultation.

The information you provide on this form may also be provided to the insurer or worker's compensation scheme agent, with your consent. The information may be used by the insurer or scheme agent in deciding liability or acceptance or rejection of a claim. It is therefore essential that you complete the information accurately and comprehensively.

If there is insufficient room on this form please attach the extra information on a separate page.

Patient

Name _____

Date of Birth _____

WC Claim number _____

Employment

Employer _____

Position / Role / Occupation _____

What is the usual nature of employment? Eg full-time _____

Pre injury hours per week worked _____

Duration of employment with this employer_____

Pre injury Duties

Please describe the nature of your pre injury duties including physical requirements for sitting or standing, bending, lifting and twisting.

_____

_____

_____

_____

_____

_____

_____

Injury

Please describe the incident and resulting injury. Include specifics such as what part of the body was injured and the manner in which the injury occurred. Please provide as much detail as possible.

Date of incident and time _____

Was the incident/injury reported? Yes / No

If so, to whom was it reported and when? _____

Describe the incident and injury. _____

_____

_____

_____

_____

_____

_____

How does your injury relate to your employment?

This is an important question. We need to understand how your injury was caused by your employment. Please provide as much information as possible

What treatments for this injury/injuries have you undertaken since the incident?

List type, duration and outcome. This may include physiotherapy, massage, cortisone injections or surgery. Please also list consultations with other physicians or surgeons.

Have you required time off work or have you had to change duties?

_____

_____

_____

_____

Are you working now? Yes / No. If so, are you performing your usual duties?

_____

_____

_____

_____

Have there been any previous work related injuries? Yes / No

If so, to what part of the body and when did they occur?

_____

_____

_____

Were they subject to a Worker's Compensation claim? Yes / No If so, provide details.

_____

_____

_____

Workers Compensation Insurer

Company / Insurer _____

Name of your case manager _____ _____

Contact phone _____

Email _____

Address _____

Legal Representation

Do you have legal representation? Yes / No

Legal Firm _____

Name of your solicitor _____

Address _____

_____

IMPORTANT

Agreement and Collection of Information Statement

I, ……., hereby acknowledge that I am seeing Professor Owler for assessment, advice and, if necessary, surgical management of my condition which is covered under Workers' Compensation or Third Party Insurance.

I have been advised that Professor Owler will complete reports and notifications to the insurer as soon as practicable but Professor Owler cannot be accountable for any delays in the process.

I understand that Professor Owler does not provide assessments of whole person impairment.

I authorise that the information concerning my condition and treatment may be forwarded to my Worker's Compensation Insurer/Third Party Insurer and/or to my Solicitor.

I undertake to be fully responsible for all outstanding fees for consultations, treatment and the cost of any medico-legal report required by my solicitor or me.

I understand that if any unpaid account is not settled within 30 days, a late payment fee of 25% will be incurred and the matter will be referred to our debt collection agency.

Signed: _____ Date: …/…/…

Collection of Information Statement

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assist, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

• Administrative purposes in running our medical practice
• Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
• Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice

I have read the information above and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am also aware that this practice has a Privacy Policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed:_____ Date: _____