

REFERRAL TO MEDICAL PANELS

Pursuant to Section 45(1)(b) of the Accident Compensation Act 1985

REQUESTOR DETAILS (TO BE COMPLETED BY COURT OFFICER)

Court Location: _____

Magistrate: _____

Case Number: _____

Phone Number: _____ Fax Number: _____

WORKER DETAILS

Worker's Full Name (SURNAME LAST): _____

Date of Birth: _____

Current Address: _____

_____ Post Code _____

Home Phone: _____ Mobile Phone _____

Is an Interpreter required? YES NO Language _____

WORKER'S SOLICITOR DETAILS

Solicitor's Name: _____

Contact Name: _____ Reference _____

Address: _____

_____ Post Code _____

Phone: _____ Fax _____

INJURY DETAILS

Injuries to be Assessed: _____

Date of Injury _____

Employer's Name _____

WORKCOVER CLAIM DETAILS

Authorised Insurer: _____

WorkCover Claim Number: _____

Relevant Section of the Act: _____