

PROFESSOR GREG BAIN

WORKCOVER

PATIENT INFORMATION SHEET

DR / MR / MST

MRS / MISS / MS _____

(SURNAME)

(GIVEN NAMES)

ADDRESS

_____ POST CODE _____

DATE OF BIRTH _____ AGE _____

TELEPHONE NO: (Home) _____ (Mobile) _____

(Work) _____ (Email) _____

Next of Kin _____ (Phone) _____

FAMILY DOCTOR'S NAME AND ADDRESS _____

MEDICARE NO _____ REF NO ____ EXP __ / __ VET AFFAIRS NO _____

PRIVATE HEALTH INSURANCE FUND _____ MEMBER NO _____

NAME AND ADDRESS OF WORKCOVER AGENT _____

_____ **CASE MANAGER** _____

CLAIM NO _____ DATE OF INJURY _____

OCCUPATION _____ EMPLOYER _____

ADDRESS OF EMPLOYER _____

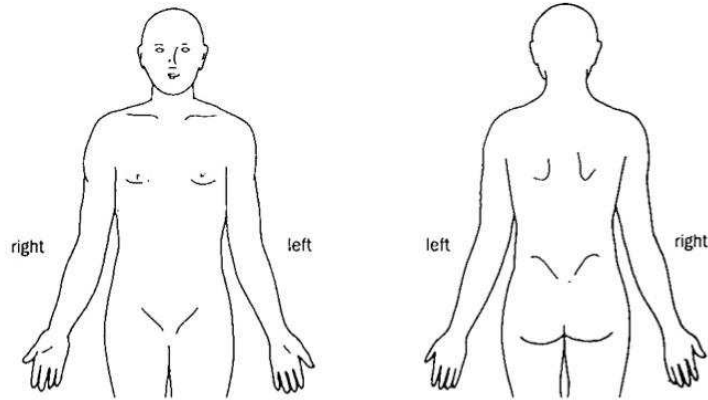
1. Date, time and location of injury:

2. Brief description of the event:

3. What problems are you currently having:

4. Description of injury or injuries (please use diagram to indicate where you feel pain – please include ALL affected areas)

Please mark on the diagram the site of pain. Also mark your worst pain with an 'x' mark any numbness with an 'o'



5. Treatment sought ie anti-inflammatory tablets, chiropractic care, physio, massage, injections, splints, xrays, MRI, blood tests etc (please include names of Practitioners seen):

6. Impact on capacity to work:

7. Impact on daily activities ie home/sport/social life etc:

8. What are your current working hours:

9. What duties are you currently performing:

10. Has your claim been accepted **YES** **NO** **Don't Know**