**HABIT HEALTH REFERRAL FOR REHABILITATION**

**(ACC CLAIMANTS)**

| **ACC Claimant Details** | |  |
| --- | --- | --- |
| Claimant Name: | | Claim no: |
| Phone no: | | Address: |
| **Injury details** |  | |
| Date of injury: | Injury description: | |
| **Referrer Details** |  | |
| Referrer Name: | Organisation: | |
| Phone number: | E-mail address: | |
| **Injury related rehabilitation needs** |  | |
| **DISCIPLINE** | **REHABILITATION REQUIRED** | |
| 🞏 PHYSIOTHERAPY | 🞏 MOBILITY  🞏 PAIN MANAGEMENT  🞏 EXERCISE (RANGE OF MOTION, STRENGTHINING) | |
| 🞏 OCCUPATIONAL THERAPY | 🞏 TRAINING FOR INDEPEDNENCE IN ADL’S  🞏 EQUIPMENT  🞏 SUPPORT NEEDS ASSESSMENT  🞏 RETURN TO PRE-INJURY WORK | |
| 🞏 PSYCHOLOGY/COUNSELLING | 🞏 Expressed “Fear of Falling”  Restricted function due to limiting beliefs post injury | |
| 🞏 SOCIAL WORK | 🞏 HOUSING / FINANCIAL / FAMILY ISSUES IMPACTING RECOVERY | |
| 🞏 VOCATIONAL CONSULTANCY | 🞏 JOB SEARCH/ INTERVIEW SKILLS / RETRAINING | |
| **Signature** |  | |
| Signature: | Date: | |

**ATTACHMENTS:**

**🞏 ACC45 🞏 OTHER**