WORKCOVER / 3rd PARTY INSURER DETAILS FORM – MUST BE COMPLETED

INSURER: Please specify **QLD** ☐ **NSW** ☐ Company: **Other** ☐ Company:

Claim Number:	**Case Manager Name:**
Case Manager Email:	**Case Manager Phone:**

Patient Occupation:

Patient Employer:

Date of Injury:

Injured Limb:

In your words, how did this injury occur?

Relevant past medical history:

Current medication/s:

Current treatment &/or rehabilitation to date:

Current capacity for work:

Is the work related condition an aggravation of any pre-exisiting condition: ***Y ☐ N ☐

***If yes please give details:

- **I acknowledge that the above information is true and correct to the best of my knowledge**
- **I understand that it is my responsibility to notify Dr Graze's rooms of any change in my workcover/3rd party insurance claim status.**
- **I agree that if at any time my claim is closed I will ensure Dr Graze's rooms are notified & if I thereafter attend an appointment with Dr Graze that I am responsible for payment of that consultation in full**

Patient Signature **Date:** / /