Kearns Medical Centre
Shop 6, 70 Kearns Avenue
KEARNS, NSW 2558
Ph: (02) 4604 6071
Fax: (02) 4604 6072
Email: info@kearnsmedical.com.au

PATIENT WORKCOVER QUESTIONNAIRE

Please complete the form below and return to reception to be included with your file – If you are unsure or need assistance, please ask reception or your Doctor

Surname:_____ First Name:_____

Address:_____

Home Tel:_____Mobile:_____

Occupation:_____ D.O.B._____

Please advise the date when the injury / Accident Occurred

Day_____ Date_____Time_____AM/PM

Is your injury related to :

WORK MOTOR VEHICLE ACCIDENT

PUBLIC LIABILITY VICTIMS COMPENSATION

OTHER_____

If WORK Related, please advise the following details:

(Also note that you must complete a work injury claim form with your employer)

Name of your employer:_____

Employers Address_____

Employers Phone Number_____

Have you reported your injury to your employer: YES NO

If yes, Who did you report the incident to ? :_____

Claim No / Insurance company (If Known):_____

When did you commence work with your employer? : _____

Please describe your duties of employment:

_____

_____

_____

How long have you been doing this type of duty?: _____

Please describe what you were doing when the injury occurred or the accident happened

_____
_____
_____

Have you had any of the previous injuries of a similar nature ?(Please list these and advise month and year of injury)

_____
_____
_____

Please list your pain and problems in order of severity

_____
_____
_____

Patient Signature_____Date_____