

INTERNATIONAL SERVICES APPOINTMENT REQUEST FORM

* = Required field

SECTION 1: Customer information	
Organisation Name*:	
Contact Name*:	
Address*:	
Position*:	Contact Name Phone*:
Contact Name Email*:	
If you are a lawyer, who do you represent?*	
How did you hear about us? vault <input type="checkbox"/> LinkedIn <input type="checkbox"/> Website <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other:.....	

SECTION 2: Client information	
Title: Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	
Reference Number:	Date of Injury:
First Name*:	Last Name*:
Address*:	
Country (client is located if different to customers listed above)*:	
Phone*:	Date of Birth*:
Email Address*:	
Interpreter Required*: Yes / No:..... Language:.....	

SECTION 3: Type of medical expert required			
Orthopaedic Surgeon <input type="checkbox"/>	Occupational Physician <input type="checkbox"/>	Psychiatrist <input type="checkbox"/>	Neurologist <input type="checkbox"/>
Other:.....			

SECTION 4: Nature of assessment & legislation / guidelines required				
Public Liability <input type="checkbox"/>	Motor Vehicle Accident <input type="checkbox"/>	Workers Compensation <input type="checkbox"/>	Comcare <input type="checkbox"/>	
FFD <input type="checkbox"/>	IP / TPD <input type="checkbox"/>	DVA <input type="checkbox"/>	Permanent impairment <input type="checkbox"/>	Telehealth <input type="checkbox"/>
Other:.....				
Please tick relevant state scheme: ACT <input type="checkbox"/> NSW <input type="checkbox"/> NT <input type="checkbox"/> QLD <input type="checkbox"/> SA <input type="checkbox"/> TAS <input type="checkbox"/> VIC <input type="checkbox"/> WA <input type="checkbox"/>				
Comments:.....				
If a permanent impairment is required, please advise legislation/accreditations required by the expert:.....				

SECTION 5: All body systems to be assessed					
Cervical Spine <input type="checkbox"/>	Shoulder L <input type="checkbox"/>	R <input type="checkbox"/>	Leg L <input type="checkbox"/>	R <input type="checkbox"/>	Psychological <input type="checkbox"/>
Thoracic Spine <input type="checkbox"/>	Elbow L <input type="checkbox"/>	R <input type="checkbox"/>	Knee L <input type="checkbox"/>	R <input type="checkbox"/>	
Lumbar Spine <input type="checkbox"/>	Hand L <input type="checkbox"/>	R <input type="checkbox"/>	Ankle L <input type="checkbox"/>	R <input type="checkbox"/>	
	Wrist L <input type="checkbox"/>	R <input type="checkbox"/>	Foot L <input type="checkbox"/>	R <input type="checkbox"/>	
Other (please specify):.....					

INFORMATION REQUIRED SO WE CAN BRIEF THE EXPERT(S)

SECTION 6: Nature of injury and/or medical condition(s) including diagnosis?*

Please list all conditions and date(s) of injury for the experts consideration:

SECTION 7: Summary of the case and customer requirements*

Please outline a summary of the case and describe what you would like to achieve from this assessment. Please include anything you wish the expert to be aware of when considering this referral:

Please save this form and send as an attachment by clicking on the following email link:

international@mlcoa.com.au