# Worker Injury Review Assessment

### **If you have any questions about this form, please call Workers Care on 1300 738 586.**

The Workers Care Program is an icare initiative to provide the best support to workers with severe injuries. Workers Care provides treatment and care to people who are severely injured at work while their employer’s workers compensation insurer continues to manage weekly payments and any other compensation. To receive services from Workers Care, the person must have been accepted NSW workers compensation claim and their injury must meet specific criteria.

Workers with a severe injury enter the program for an initial period of two years. Before the end of the two years, the worker’s injuries are reviewed to see if they still meet the severe injury criteria. In some instances where an injury hasn’t stabilised, this review may be deferred for up to one year. Once reviewed, if the severe injury criteria is met, Workers Care will continue to meet the worker’s ongoing treatment and care needs, as long as they have an accepted workers compensation claim. If the severe injury criteria is not met, the management of treatment and care will return to the insurer. Severe injuries include:

* Brain injury (moderate to severe)
* Spinal cord injury
* Multiple amputations or specific unilateral amputations (or brachial plexus injury)
* Burns (full thickness burns)
* Permanent blindness

### About this form

This form is for workers who are approaching the severe injury review point. We need the information in this form to decide whether the injury continues to meet the severe injury criteria.

### What you need to do

* Complete Part A of this form
* Please sign the authority to collect information (a relative, friend, guardian or legal representative may sign on your behalf if you are unable to)
* Return the form using the reply-paid envelope or Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) or
* Fax: 1300 738 583

### Next steps

* We will then arrange for your treating specialist to complete Part B which is a Medical certificate.
* We will review the information and advise you and the insurer of our decision or if further information is needed.

Interpreter services  
Contact Associated Translators and Linguists on (02) 9231 3288 (between 8:30am and 5 pm Monday to Friday) if you need an interpreter.

## Privacy: How we collect, use and disclose your personal and health information

### Information about the accident

Workers Care needs information about the accident and your injuries to decide if your injury meets the criteria for Workers Care. This may include information collected from or about other people involved in the accident, including witnesses and emergency services.

In signing the consent form on the certificate of capacity you have authorised Workers Care by law to share personal and health information about the accident, and about your injuries and treatment, with your medical practitioner, your employer, other treating practitioners and workplace rehabilitation providers.

### Information about your health

Workers Care will also collect health information about you from other people, including health service providers. Health information may include information about your workplace injury, pre-accident and general medical information about you.

### Information about you

Workers Care needs information about your care, support and housing situation so that your needs can be met and the program can be well-managed. This may include information collected from, or about, other people involved in your life, such as family, friends and carers.

### Information about your treatment and care needs

If your injury meets the criteria, Workers Care will pay for all of your reasonably necessary treatment and care services. Workers Care will need to communicate with a range of organisations and other people about your ongoing treatment and care needs. This may involve collection of information from and disclosure to any of the following: Your family or guardian; health service providers; other service providers; your case manager or other community/social workers, educational facilities (e.g. school or TAFE), other government agencies, employers, lawyers and insurers. Any of these may also engage contractors or service providers who may need to collect, use or disclose your personal or health information.

### Disputes

If there is a dispute about the nature of your injuries or your treatment and care, Workers Care may need to share your information with the Personal Injury Commission, Independent Medical Officers, other government agencies and solicitors. They will be provided with the same personal and health information that Workers Care holds about you. They may also require additional information to help them in their assessment.

### Other uses and disclosures

In exceptional circumstances, Workers Care may need to provide personal or health information to third parties; for example, to the police for law enforcement, or in emergencies (such as where there is a serious imminent threat to your life or health or that of another person). Workers Care may also use information about workers for program evaluation, customer feedback surveys and research, and this may be undertaken by contractors. If this happens, research results will only be published in de-identified form or with your express consent.

## Your privacy rights

The laws in NSW governing your personal and health information are the Privacy and Personal Information Protection Act 1998 (NSW) and the Health Records and Information Privacy Act 2002 (NSW). You may request access to personal or health information held about you by Workers Care at any time. Please contact your Workers Care contact if you wish to access your information. If you have concerns about Workers Care sharing your personal or health information with a particular service or family member, please contact Workers Care to discuss the issue. To request access or correction, to make a privacy related complaint or for more information about our privacy obligations, email privacy@icare.nsw.gov.au or write to the Privacy Officer at GPO Box 4052, Sydney NSW 2001.

## Worker Injury Review Assessment

## Part A

### 1. Personal details

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** | | **Middle Name** | | | **Surname** | | | |
|  | |  | | |  | | | |
| **Other names known by** | **Gender** | | | | | | | |
|  | **Male**  **Female**  **Other**  **Prefer not to say** | | | | | | | |
| **Date of birth (DD/MM/YYYY)** | | | **Claim number** | | | **Date of injury (DD/MM/YYYY)** | | |
|  | | |  | | |  | | |
| **Telephone** | | | **Mobile phone** | | | **Email** | | |
|  | | |  | | |  | | |
| **Address** | | | | | | | | |
|  | | | | | | | | |
| **Suburb** | | | | **State** | | | | **Postcode** |
|  | | | |  | | | |  |
| **Postal Address (if different from above)** | | | | | | | | |
|  | | | | | | | | |
| **Suburb** | | | | **State** | | | | **Postcode** |
|  | | | |  | | | |  |
| **Is an interpreter required?** | | | | | | | **Language** | |
| No  Yes – complete interpreter declaration on page 10 | | | | | | |  | |

### 2. Personal details of person responsible

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **First name** | | **Surname** | | | |
|  | |  | | | |
| **Relationship to injured person** | **Home phone** | | | **Work phone** | |
|  |  | | |  | |
| **Mobile** | | **Email** | | | |
|  | |  | | | |
| **Address** | | | | | |
|  | | | | | |
| **Suburb** | | | **State** | | **Postcode** |
|  | | |  | |  |

### **3. Authority to collect information**

Please read carefully before signing.

This Authority must be signed by the injured person, or the injured person’s relative, friend, guardian or other legal representative. The person who signs this form must be over 18 years of age.

I authorise Workers Care to collect from and disclose to the parties listed below my personal and health information relevant to my injury, treatment, rehabilitation and care needs, and to any related compensation claim. Relevant parties include:

* a relative, friend, guardian or other legal representative
* your current, former or prospective employer, or current of former work colleague or any other persons who can provide information regarding your employment arrangements;
* an insurer carrying on the business of providing workers’ compensation, CTP Insurance or personal injury insurance
* a social or community worker
* a medical or health care practitioner or service provider, including hospitals (including private)
* an ambulance and/or other emergency services
* a person who is qualified to assess the treatment, care, and support needs of a person
* Personal Injury Commission (if a dispute arises)
* any person to whom disclosure is ordered by a tribunal or court
* Commonwealth or State government departments or agencies involved in my case, including Centrelink, Medicare, NSW Family and Community Services, NSW State Insurance Regulatory Authority (SIRA) the Lifetime Care and Support Authority and an educational institution (e.g. TAFE)
* If you live or travel overseas, any private or government entity necessary to deliver treatment and care services to you or otherwise manage your participation in the scheme,
* any other person to whom icare is required to disclose the information by law  
  third party contractors engaged by icare to deliver any aspect of the management of the workers compensation scheme including a quality auditor engaged by contract to review management of the scheme; and
* any legal practitioner engaged in representing a party making a claim for compensation or damages (including personal injury, workers compensation or CTP).

I understand that information obtained under this Authority may include pre-accident and general medical information. I understand that my information may be used for the purposes explained in the section of this form headed Your Privacy: how we collect, use and disclose your information.

|  |  |
| --- | --- |
| **Name of injured person** | |
|  | |
| **Signature of injured person** | **Date** |
|  |  |

### **Complete this section if another person is completely this Authority of behalf of the injured person**

|  |  |
| --- | --- |
| **Name of person** | **Signature of person** |
|  |  |
| **Date** | **Relationship to injured person** |
|  |  |
| **Reason why the injured person could not sign** | |
|  | |

## Part B

### Medical certificate

|  |  |
| --- | --- |
| **First name(s) of injured person** | **Surname of injured person** |
|  |  |

Was the injury described below caused by the workplace accident?

Yes  No

Are the injuries consistent with the circumstances of the workplace accident described to you?

Yes  No

Does the injury meet the severe injury criteria as set out below?

Yes (complete boxed section(s) below)  No

### Please complete all the applicable severe injury categories

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Brain injury I certify that the injured person has sustained a brain injury caused by the workplace accident. The brain injury meets the following criteria, as outlined below:  Complete both sections below:   The duration of PTA is greater than 1 week.   |  |  |  | | --- | --- | --- | | Number of days in PTA |  | *Attach PTA scoring sheets* |   If the PTA score is not available or not applicable (for example, if the injured person has a penetrating brain injury):  There is evidence of a very significant impact to the head causing coma for longer that one hour. Where coma has been documented, attach a copy. If not, describe in the box below how this was determined;  **OR**  There is significant brain imaging abnormality, e.g. penetrating injury. Describe in the box below why the abnormality is significant.   |  | | --- | |  |   Attach a copy of the imaging report/s.  **AND**  The injured person has scored 5 or less on any of the items on the FIM, due to the brain injury, within the last month and **I agree with this FIM assessment.** |  |

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| --- | --- | --- | --- | --- | --- |
| Spinal cord injury (permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction)  I certify that the injured person has sustained a spinal cord injury caused by the workplace accident. The spinal cord injury meets the spinal cord injury criteria as outlined below:  The spinal cord injury is an acute traumatic lesion of the neural elements (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction.   |  |  |  |  | | --- | --- | --- | --- | | Neurological (SCI) level: |  | ASIA impairment scale: |  |   Attach ASIA score sheet |  |

|  |  |
| --- | --- |
| Amputation/sI certify that the injured person has sustained amputation/s (or equivalent impairment) caused by the workplace accident. The amputation is one of the following types of amputations, as outlined below:1. Multiple amputations Multiple amputations of the upper and/or lower extremities, meaning that there is more than one of the following types of amputation at or above the level of: | |
| * a short transtibial or standard transtibial amputation, as defined by the loss of 50% or more of the length of the tibia. This includes all other amputations of the lower extremity (such as knee disarticulation or transfemoral amputation) above this level | Right  Left |
| * a thumb and index finger of the same hand, at or above the first metacarpophalangeal joint. This includes all other amputations of the upper extremity (such as below-elbow or above-elbow amputation) above this level | Right  Left |
| 2. Unilateral amputations The amputation is one of the following: | |

|  |  |
| --- | --- |
| * forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation | Right  Left |
| * hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy | Right  Left |
| * hip disarticulation (complete amputation of the femur) | Right  Left |
| * short transfemoral amputation as defined by the loss of 65% or more of the length of the femur | Right  Left |
| * brachial plexus avulsion or rupture resulting in partial or total paralysis (provide details below) | Right  Left |

|  |
| --- |
| Permanent blindness I certify that the injured person has sustained permanent blindness caused by the workplace accident. The loss of sight meets one of the following criteria, as outlined below:  a) visual acuity on the Snellen Scale or equivalent after correction by suitable lenses is less than 6/60 in both eyes; or  b) field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object); or  c) a combination of visual defects resulting in the same degree of visual loss as that occurring in (a) or (b) above. |

|  |  |
| --- | --- |
| Burns I certify that the injured person has sustained full thickness burns caused by the workplace accident. The injury meets one of the following criteria, as outlined below:    The injured person is a child under 16 that has full thickness burns greater than 30% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment  **OR**    The injured person has full thickness burns greater than 40% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.  **AND**    The injured person has a score of 5 or less on any of the items on the FIM, due to the burns, within the last month and **I agree with this FIM assessment.**  Attach FIM™ or WeeFIM® score sheet |  |

### **Other injuries**

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| --- |
|  |

### Treating specialist declaration

I declare that I have examined the nominated patient and to the best of my knowledge the information provided here is true and correct.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of treating specialist** | | | **Qualification** | | |
|  | | |  | | |
| **Signature** | | **Provider number** | | | **Date** |
|  | |  | | |  |
| **Address** | | | | | **Phone** |
|  | | | | |  |
| Interpreter assistanceIf you need an interpreter to help you read and/or fill in this form, contact Associated Translators & Linguists Pty Ltd on (02) 9231 3288 between 8.30am to 5.00pm, Monday to Friday. This is a free service. If you do need an interpreter to help you with this form, the declaration below must be completed by the interpreter and the injured person, or their parent, family member or guardian.Interpreter declaration  1. I declare that the Worker Injury Assessment Form has been read to the undersigned injured person, their parent, family member or guardian by the undersigned interpreter. 2. I understand that the Workers Care Program and Associated Translators & Linguists Pty Ltd bear no responsibility for any loss whatsoever arising from the interpreting service provided. 3. I acknowledge that the interpreting service provided by Associated Translators & Linguists Pty Ltd was limited to reading and filling in this **Application Form**. 4. This declaration has been read to the injured person, their parent, family member or guardian by the undersigned interpreter.  |  |  |  | | --- | --- | --- | | **Name of injured person** | **Injured person’s signature (or person responsible)** | | |  |  | | | **Injured person’s address (or parent, family member, guardian)** | | **Date** | |  | |  | | | | | | |
| **Interpreter’s name** | | | **Interpreter’s signature** | | |
|  | | |  | | |

## Checklist

Before sending this form to Workers Care please ensure you have completed the following steps

Medical Certificate and FIM, PTA or ASIA worksheets completed and attached

A copy of this form and any accompanying information has been made for your own records

A copy of this form has been given to the worker

|  |  |
| --- | --- |
|  | Workers Care GPO Box 4052, Sydney, NSW 2001 **General Phone Enquiries: 1300 738 586** Fax: 1300 738 583 Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |