# Worker injury assessment form

### If you have any questions about this form, please call the Workers Care Program 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 an accepted NSW workers compensation claim and their injury must meet specific criteria. 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

### Who can complete this form?

This form should be completed by an insurer when they have accepted liability for a workplace injury and it is likely to be severe.

We need the information in this form to decide whether the injury meets the severe injury criteria.

**Do not proceed with this form if liability is not determined.**

### Information for insurers

* Worker consent (page 7) should be completed by the worker or their relative, friend, guardian or legal representative if they are unable to sign.
* Medical certificate (pages 8-11) should be completed by the worker’s treating specialist (e.g. Rehabilitation specialist; Spinal Physician).

**Where do I send this from when it is completed?**

**Mail: GPO Box 4052, Sydney NSW 2001**

**Fax: 1300 738 583**

**Email: care-requests@icare.nsw.gov.au**

### About the information in this form and next steps

* Workers Care will review the information and contact the worker and insurer to advise our decision or if further information is needed.
* If the injury meets the severe injury criteria, Workers Care will pay for all reasonably necessary hospital, medical, rehabilitation and attendant care expenses according to the Workers Compensation Guidelines. The insurer will provide any other compensation that may be payable such as weekly payments.

### Interpreter services

Contact Associated Translators and Linguists on 02 9231 3288 (between 8:30am and 5pm Monday to Friday) if the worker or person signing this form needs an interpreter.

## Information for injured workers

Your privacy

*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.

As you have lodged an insurance claim, Workers Care is authorised by law to share information about the accident, and about your injuries and treatment, with any insurance company involved.

*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, where relevant.

*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 (eg 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. Workers Care may also use information about workers for program evaluation 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 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, 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.

## Personal details of the injured person

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | Telephone | |
|  |  | | | |  | |
| Mobile | Email | | | | | |
|  |  | | | | | |

Address

|  |  |  |
| --- | --- | --- |
| Address | | |
|  | | |
| Suburb | State | Postcode |
|  |  |  |

Postal address (if different)

|  |  |  |
| --- | --- | --- |
| Address | | |
|  | | |
| Suburb | State | Postcode |
|  |  |  |
| To ensure we consider your cultural needs for the services and support you may be eligible for: | | |
| Are you a First Nations person? | | |
| Yes - Aboriginal  Yes – Torres Strait Islander  Yes, both Aboriginal and Torres Strait Islander  If yes, what is your Nation/Country?  No  I do not wish to disclose  Unknown | | |

|  |  |
| --- | --- |
| Do you identify with another culture? | |
| Yes If yes, which culture?  No  I do not wish to disclose  Cultural identity unknown | |
| Do you require an interpreter? | If yes, for what language |
| Yes – complete interpreter declaration on page 12  No |  |

## Personal details of person responsible (see p1, “Who can complete this form?")

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First name | | | | Surname | | | | | |
|  | | | |  | | | | | |
| Relationship to injured person | | Home Phone | | | | | Work phone | | |
|  | | |  | | | | |  | |
| Mobile | Email | | | | | | | | |
|  |  | | | | | | | | |
| Address | | | | | | | | | |
|  | | | | | | | | | |
| Suburb | | | | | State | | | | Postcode |
|  | | | | |  | | | |  |
| Is an interpreter required? | | | | | | If yes, for what language | | | |
| Yes – complete interpreter declaration on page 12  No | | | | | |  | | | |

## Solicitor contact details

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First name | | | | Surname | | |
|  | | | |  | | |
| Role / title | | Company | | | Telephone | |
|  | | |  | | |  |
| Mobile | Email | | | | | |
|  |  | | | | | |

Postal address

|  |  |  |
| --- | --- | --- |
| Address | | |
|  | | |
| Suburb | State | Postcode |
|  |  |  |

## Employer contact details

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First name | | | | Surname | | |
|  | | | |  | | |
| Employer role / title | | Company | | | Telephone | |
|  | | |  | | |  |
| Mobile | Email | | | | | |
|  |  | | | | | |

Postal address

|  |  |  |  |
| --- | --- | --- | --- |
| Address | | | |
|  | | | |
| Suburb | State | | Postcode |
|  |  | |  |
| Is an interpreter required? | | If yes, for what language | |
| Yes – complete interpreter declaration on page 13  No | |  | |

## Accident details

|  |  |
| --- | --- |
| Date of the accident (DD/MM/YYYY) | Nature of the accident |
|  |  |
| Date liability accepted (DD/MM/YYYY) | |
|  | |
| Was a motor vehicle involved in the accident (including forklifts)? | |
| Yes  No | |
| Has a CTP claim or Lifetime Care and Support application been submitted? | |
| CTP claim  Lifetime Care and Support application  No | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| CTP Insurer’s name | Claim Number | | CTP Insurer’s contact person | |
|  | |  | |  |

## Injury details

What are the injuries as a result of the accident?

Brain injury  Spinal cord injury  Amputation / Brachial plexus injury  Burns  Blindness

|  |  |  |
| --- | --- | --- |
| Other injuries | | |
|  | | |
| Did the injured person need an ambulance? | Did the injured person go to hospital after the accident? | |
| Yes  No | Yes  No | |
| If yes, which hospital? | | Date attended (DD/MM/YYYY) |
|  | |  |
| Was the injured person admitted to a hospital or rehabilitation facility? | | |
| Yes  No | | |
| If yes, list below: | |  |
| Hospital or rehabilitation facility | | Date attended (DD/MM/YYYY) |
|  | |  |
| Hospital or rehabilitation facility | | Date attended (DD/MM/YYYY) |
|  | |  |
| Hospital or rehabilitation facility | | Date attended (DD/MM/YYYY) |
|  | |  |
| Has the injured person been discharged from hospital? | | |
| Yes  No | | |
| If yes, which hospital | | Date discharged (DD/MM/YYYY) |
|  | |  |

## Insurer contact

|  |  |
| --- | --- |
| First name | Surname |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Role / title | | Company | | Telephone | |
|  | | |  | |  |
| Mobile | Email | | | | |
|  |  | | | | |

Postal address

|  |  |  |
| --- | --- | --- |
| Address | | |
|  | | |
| Suburb | State | Postcode |
|  |  |  |

## Authority to collect your 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 icare Workers Care Program 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 may be:

* a relative, friend, guardian or other legal representative
* a current, former or prospective employer
* an insurer carrying on the business of providing workers’ compensation, CTP Insurance or personal injury insurance
* a health care practitioner or service provider, including the ambulance service and hospitals
* a social or community worker
* a legal practitioner or an insurance company involved in my case
* 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, the Lifetime Care and Support Authority or an educational institution (eg TAFE)
* any other person to whom icare is required to disclose information by law

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.* I understand that I can withdraw or modify my consent at any time.

|  |  |
| --- | --- |
| Name of injured person | |
|  | |
| Signature of injured person or representative | Date (DD/MM/YYYY) |
| Signature of injured person or representative |  |

Complete this section if another person is completing this Authority on behalf of the injured person

|  |
| --- |
| Name of injured person representative |
|  |
| Relationship to injured person |
|  |
| Reason why the injured person could not sign |
|  |

## Medical certificate (to be completed by treating specialist)

|  |  |
| --- | --- |
| First name 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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 9.1 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 the injured person has a penetrating brain injury):  There is evidence of a very significant impact to the head causing coma for longer than 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**.  *Attach FIM scoresheet. Icare FIM scoresheet is preferred. To locate form on the icare website go to www.icare.nsw.gov.au > Practitioners & providers > Forms and resources > Workers Care Program > FIM scoresheet - Brain injury* |

|  |  |
| --- | --- |
| First name of injured person | Surname of injured person |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 9.2 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 in the spinal canal  (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* |

|  |  |
| --- | --- |
| 9.3 Amputation/s Equivalent impairment means that the person’s limb function is equivalent to an amputation described below.  I certify that the injured person has had one or more amputation/s (or equivalent impairment) caused by the workplace accident.  The injury meets the criteria, 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, proximal to, 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 |
| * there are multiple amputations, each of which is an equivalent impairment to an amputation described above (provide details below) | Right  Left |
| * there is at least one amputation and at least one equivalent impairment to an amputation described above (provide details below) | Right  Left |
| Comments   |  | | --- | |  |   2. Unilateral amputations or brachial plexus injury  The amputation (or equivalent impairment) 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; or | Right  Left |
| * brachial plexus avulsion or rupture resulting in an equivalent impairment to an upper limb amputation (provide details below) | Right  Left |
| * an equivalent impairment to any of the injuries described above (provide details below) | Right  Left |
| * Severe orthopaedic and/or neuromuscular injury of either an upper or lower limb producing an equivalent impairment to the injuries described above (provide details below) | Right  Left |
| Comments   |  | | --- | |  | | |

|  |  |
| --- | --- |
| First name of injured person | Surname of injured person |
|  |  |

|  |  |
| --- | --- |
| 9.4 Permanent blindness I certify 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. |  |

|  |  |
| --- | --- |
| 9.5 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 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 scoresheet. Icare FIM scoresheet is preferred. To locate form on the icare website go to www.icare.nsw.gov.au > Practitioners & providers > Forms and resources > Workers Care Program > FIM scoresheet - Burns* |  |

### 9.6 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 medical specialist\* | Qualification | | |
|  |  | | |
| Signature of treating specialist | Provider number | | Date |
| Signature |  | |  |
| Address | | Phone | |
|  | |  | |

## Interpreter assistance

If 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 icare 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 (or parent, family member, guardian) | Injured person’s signature (or person’s representative) | Date |
|  | Signature |  |
| Interpreter’s name | Interpreter’s signature |  |
|  | Signature |  |

## ****11. Checklist****

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

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

Relevant imaging attached

A copy of this completed 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** Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |