Appin Medical Centre
1/74 Appin Road,
Appin NSW 2560
P:02 4488 1090
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Email: info@appinmedical.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_____________