Kairros Referral Form

KAIRROS
Injury Management Professionals

Who is completing this form?

☐ Insurance Agent ☐ Employer ☐ Health Professional ☐ Government Support Official ☐ Worker

Your Full Name | Your Phone Number | Your Email

Worker / Client Details

Title | Client First Name | Client Last Name

Client Address

Suburb | State | Postcode

Client Phone | Client D.O.B ___ / ___ / ___ | Client Gender ☐ M ☐ F ☐ X

Client Usual Occupation | Interpreter Required? Language? | Date of Injury

Nature of Injury (please provide as much detail as possible)

Insurer Details

Title | Last Name | First Name

Company Name

Company Address

Suburb | State | Postcode

Phone | Email | Claim No.

Billing Address

Kairros Referral Form

Employer Details

Title | First Name | Last Name

Company Name

Company Address

Suburb | State | Postcode

Phone | Email | Fax

Treating Practitioner Details

Treater Type

☐ GP ☐ Physiotherapist ☐ Specialist ☐ Psychologist ☐ Psychiatrist ☐ Chiropractor ☐ Surgeon ☐ Other

Title | First Name | Last Name

Treating Practitioner Medical Centre/Clinic Name

Company Address

Suburb | State | Postcode

Phone | Email | Fax

Additional Treating Practitioner Details

Treater Type

☐ GP ☐ Physiotherapist ☐ Specialist ☐ Psychologist ☐ Psychiatrist ☐ Chiropractor ☐ Surgeon ☐ Other

Title | First Name | Last Name

Treating Practitioner Medical Centre/Clinic Name

Company Address

Suburb | State | Postcode

Phone | Email | Fax

Additional comments or information

Would you prefer to complete your referral offline? You can download our PDF referral form here. Once you have enter the details, save your form and email it to referrals@kairros.com.au