JLT 01

INJURY MANAGEMENT
CONFIRMATION of SERVICES FORM

Worker's Name ________________________________ **Claim No.** _______ **Employer** ______________________

Referring Doctor ____ **Date of Injury** ____________________

Service Provided ☐ **Physiotherapy** ☐ **Occupational Therapy** ☐ **Psychology**

☐ **Chiropractic** ☐ **Other – specify** ______________________________________

Provider's Name ___________________________________ **Phone** ________________ **Fax** _________________

Address ____

TREATMENTS ONLY

Date of Service	Description of Service	Injury/Area Treated	Signature of Worker
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

SERVICES REQUIRING PRIOR APPROVAL: Local Government Workcare will not pay for any services requiring prior approval unless provided in accordance with the relevant Q-COMP Table of Costs.

OTHER SERVICES

Date Supplied	OTHER SERVICES (Travel/ Items Supplied etc)	Signature of Worker

SERVICE PROVIDER AUTHORISATION

I ____________________________________, being the provider of the above services, or the person authorised on the provider's behalf, verify that the above services/items detailed on this form have been provided on the dates indicated.

Signature **Print Name** **Date**

Post/Fax to: **Jardine Lloyd Thompson**
PO Box 2321
FORTITUDE VALLEY BC QLD 4006

Fax: 3000 5560
Phone: 3000 5530

LGW use only

Comments ____

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Signature ___________________________________ **(Case Manager)** **Date** ______________________________