**INITIAL INTERVIEW – INFORMATION CHECKLIST**

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| --- | --- | --- | --- | --- |
| **Worker Details** | | | | |
| Worker’s Name |  | | | |
| Occupation |  | | | |
| Manager/Supervisor Name |  | | Contact Details: | |
| Date of Meeting | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ | | | |
| Non-English Speaking Background (NESB) | 🞎 No 🞎 Yes If Yes, interpreter present 🞎 Yes 🞎 No | | | |
| **Initial Meeting** | | | | |
| 🞎 Injury Management forms have been completed and contents explained where needed  🞎 Confirm that worker has received all documents listed in the Claim Pack, including Know Your Rights Brochure & RTW Brochure  🞎 Medical Authority signed and dated available  🞎 Role of Claims Consultant and Injury Management Business Partner explained  🞎 Specific rights and responsibilities outlined:  □ Confidentiality □ representative present at meetings □ active participation of all parties  □ Right of choice for treating doctors/medical providers □ mutuality obligation to participate  🞎 Consecutive WCCs are required for all time lost until medically cleared. Backdated WCCs not acceptable. Ensure worker is aware that medical restrictions apply 24/7  🞎 Discuss with worker that medical appointments are to be scheduled outside of approved working hours if possible (exception may be specialist consult, etc)  🞎 Discuss with worker activities of daily living needs and supports available  🞎 Discuss benefits of remaining at work, suitable and alternative duties  🞎 Need to inform Manager and Injury Management Business Partner if there are any changes in circumstances, eg. new restrictions, interstate or overseas travel, requests for annual leave, change of address, etc.  🞎 Discuss reasonable medical expenses and travel and expenses reimbursement.  🞎 Discuss and develop Return to Work Plan  🞎 Provide Injury Management Business Partner contact details for questions or concerns | | | | |
| **Worker Acknowledgement** | | | | |
| ………………………………………  Injury Management Business Partner Name | | ………………………………………  Signature | | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_  Date |
| ………………………………………  Worker Name | | ………………………………………  Signature | | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_  Date |
| 🞎 Copy to Worker | | 🞎 Copy to Claims Consultant | | 🞎 Copy in RTW file |