**COURT REFERRAL TO MEDICAL PANELS**

**Pursuant to Section 274**

**Workplace Injury Rehabilitation and Compensation Act 2013**

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| 1. **COURT DETAILS**
 |
| **COURT:** |  | **COURT****LOCATION:** |  |
| **MAGISTRATE / JUDGE:** |  |
| **CASE NO:** |  |
| **Telephone:** |  | **Facsimile No:** |  |
| 1. **WORKER DETAILS (Plaintiff)**
 |
| **Given Name:** |  |
| **Surname:** |  |
| **Postal Address:** |  |
| **Telephone Home:** |  | **Mobile Phone:** |  |
| **Email Address:** |  |
| **Date of Birth:** |  | **Gender:** |  |
| **Interpreter Required:** |  | **Language / Dialect:** |  |
| **Has the Plaintiff been to Medical Panels before?** |  | **Does the Plaintiff have a Litigation Guardian?:** |  |
| 1. **WORKER LEGAL REPRESENTATIVE**
 |
| **Name:** |  |
| **Organisation:** |  |
| **Address:** |  |
| **Telephone:** |  | **Facsimile No:** |  |
| **Email Address:** |  | **Reference No:** |  |

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| 1. **DEFENDENT / DETAILS**
 |
| **Name / Organisation:** |  |
| **Address:** |  |
| **Contact Person:** |  | **Telephone No:** |  |
| 1. **DEFENDENT LEGAL REPRESENTATIVE DETAIL**
 |
| **Name:** |  |
| **Organisation:** |  |
| **Address:** |  |
| **Telephone:** |  | **Facsimile No:** |  |
| **Email Address:** |  |
| **Reference No:** |  |
| 1. **AGENT or SELF INSURER DETAIL**
 |
| **Name:** |  | **Title:** |  |
| **Organisation:** |  |
| **Address:** |  |
| **Telephone:** |  | **Facsimile No:** |  |
| **Email Address:** |  |
| **Claim No :** |  |
| **Relevant Section of the Act** |  |
| 1. **INJURIES TO BE ASSESSED**
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**Completed Forms and Court Documents should be submitted to:**

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| Convenor of Medical PanelsLevel 6485 La Trobe StreetMelbourne Vic 3000 | For further information please contact the Medical Panels office on:Tel: 8256-1555Fax: 8256-1550 |
| **IMPORTANT: Please ensure all documents are provided in the order as outlined in the Schedule of Attachments.** |