ACCESS | REHAB

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REFERRAL FORM

Patient Information

First Name: ____________________ Last Name: ____________________

Address: ____________________ Gender: ____________________

Phone: ____________________ Cell: ____________________

Date of Birth: ____________________ (YYYY/MM/DD) Date of Accident: ____________________ (YYYY/MM/DD)

Injuries: ____________________

- ☐ Multidisciplinary Rehabilitation Program
- ☐ In Home ADL Assessment / Benefit Claimed: (Housekeeping / Caregiving / Non-earner)
- ☐ Form 1 / Assessment of Attendant Care Needs
- ☐ Work-site / Physical Demands Analysis
- ☐ Functional Abilities Evaluation (FAE) (Purpose: Return to Work / Treatment Plan Prep.)
- ☐ Psychological Assessment / Counseling
- ☐ Rebuttal Assessment
- ☐ Orthopaedic Assessment
- ☐ Physiatry Assessment
- ☐ Rheumatology Assessment
- ☐ Neurological Assessment
- ☐ Chronic Pain Assessment
- ☐ TMJ (Temporomandibular Joint) Assessment
- ☐ Future Cost of Care and Loss of Earning Capacity

Interpreter: ☐ No ☐ Yes Language: ____________________

Insurance Information

Insurance Company: ____________________ Claim #: ____________________ Policy #: ____________________

Address: ____________________

Adjuster Name: ____________________

Phone: ____________________ Fax: ____________________

Legal Representative Information

Name: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

Physician Information

Name: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

Employment Information

Employed: YES or NO

Returned to Work: YES or NO

Company Name: ____________________

____

Job Title: ____________________

Supervisor: ____________________

Work Number: ____________________

FAX REFERRAL TO: 416-987-6855