

REFERRAL FORM

Referring Party		Referral Company Name/Address
Lawyer <input type="checkbox"/>	Insurance Company <input type="checkbox"/>	_____
WSIB <input type="checkbox"/>	Ltd. Co. <input type="checkbox"/>	_____
Private <input type="checkbox"/>	Other: <input type="checkbox"/>	Referral Company Email _____
Referral File/Claim #: _____	Policy Holder Name: _____	Referral Co. Phone _____
		Referral Co. Fax _____

Client Name _____	Date of Accident _____
Date of Birth _____ Phone _____	Benefits:
Address _____	Income Replacement <input type="checkbox"/> Non Earner <input type="checkbox"/>
_____	Attendant Care <input type="checkbox"/> Caregiver <input type="checkbox"/>

Task/Assessment Required	
<input type="checkbox"/> Assessment of Attendant Care Needs (Form 1) <input type="checkbox"/> Pre-claim Examination <input type="checkbox"/> Independent Medical/Insurer's Examinations <input type="checkbox"/> Activities of Normal Living Assessment <input type="checkbox"/> Housekeeping/Home Maintenance Assessment <input type="checkbox"/> Physical Demands Analysis	<input type="checkbox"/> Home Safety Assessment <input type="checkbox"/> Childcare Assessment <input type="checkbox"/> Caregiver Assessment <input type="checkbox"/> Ergonomic Worksite Assessment <input type="checkbox"/> Occupational Therapy Assessment
Other: _____	
Referral Date: _____	

Comments
<input type="checkbox"/> Call for further details
<input type="checkbox"/> Medical Information forwarded by mail/courier
Other Comments: _____
