Rehab/Disability Management - Referral Form

Referral Type: STD/LTD Insurer:☐ Auto Insurer: ☐ Employer:☐ Other:☐ Date:

Referral Contact:	Title:
Company/Firm:	Address:
Phone:	Fax:
Email:	Reporting: ☐ Email ☐ Mail ☐ SecureDocs
Referral Contact Supervisor Name:	

Claimant/Employee/Client Information:

First Name:	Last Name:
Date of Birth:	DOL/DOD:
Address:	COD:
Gender: ☐ Male ☐ Female	Phone:
	Claim/Policy #:

Medical Information: / Vocational Information:

Medical Information	Vocational Information
Diagnosis:	Occupation:
Symptoms/ Impairments:	Employer/ Address:
Physician:	Contact:
Address:	Phone:
Phone:	Email:

Service(s) Requested:

Case Mgmt: ☐ 1 pt ☐ 2 pt ☐ 3 pt Enhanced Case Mgmt: ☐ Pharmacogenetic Testing ☐ Cognitive Screening ☐ Psycho-Social Screening ☐ Job Search Preparation Program 2 wk_____4wk_____ ☐ Supported Job Search 8 wk_____12 wk_____ ☐ Computer Fundamentals Program: Basic 4 wk____ With Excel: 6 wk _____8 wk_____	☐ Vocational Assessment ☐ TSA ☐ Paper ☐ Telephonic ☐ In-Person ☐ LMS ☐ Psycho-Voc Assessment ☐ Psycho-Ed Assessment ☐ RTW Coordination ☐ ACE - Mental Health Fitness Assessment/Cognitive Screen ☐ Cognitive Behavioural Therapy	☐ Progressive Goal Attainment Program (PGAP) ☐ FAE 1 day:___ 2 day:_____ ☐ JSA/PDA ☐ Cognitive Demands Analysis ☐ Ergonomic Assessment ☐ In-Home OT/ADL Assessment ☐ Work Conditioning/Hardening ☐ Customized Reactivation Program
Other:	Timeframe Required:	

Additional Information:

Interpreter required: ☐ Yes ☐ No	Language:
Assessment to be conducted in: ☐ English ☐ French	Report to be written in: ☐ English ☐ French
Transportation required: ☐ Yes ☐ No	Other:
Special Instructions:	

Thank you for your referral! To send securely, please upload via the SecureDocs link on our website.