AGS
MOVING YOU FORWARD

Disability Management - Self Referral Form

Date:

EMPLOYEE INFORMATION

First Name:	**Last Name:**
Address:	**Date of Birth:**
Phone Number(s):	**Personal Email:**
	Gender: ☐ Male ☐ Female ☐ Other
First Date of Absence:	

EMPLOYER INFORMATION

HR Contact:	**Title:**
Company/Firm:	**Address:**
Phone: **Ext:**	**Fax:**
Email:	**Other:**

VOCATIONAL INFORMATION

Occupation:	**Manager:**
Address:	**Contact/Title:**
Phone: **Ext:**	**Email:**

MEDICAL INFORMATION

Original Diagnosis:	**Current Diagnosis (if changed):**
Symptoms:	**Restrictions/ Limitations:**
Family Physician:	**Specialist:**
Address:	**Address:**
Phone: **Ext:**	**Phone:** **Ext:**
Next Appointment Date:	**Next Appointment Date:**

PLEASE EXPLAIN THE NATURE OF YOUR ABSENCE (MEDICAL INFORMATION WILL REMAIN CONFIDENTIAL)

Please note your employer will need to verify your referral request. Contact may take 1-2 business days.

To send your referral form securely, please upload along with supporting documents using SecureDocs link on our website. http://agsrehab.com/referrals/

Thank you for your referral.

Submit Form

Send to secure AGS email by clicking the box above