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Disability Management Referral Form

Claim Identifier:	**Referral Date:**

REFERRAL SOURCE INFORMATION

Referral Contact:	**Title:**
Company:	**Address:**
Phone: **EXT:**	**Fax:**
Email:	**Other:**
Preferred contact method: ☐ Email ☐ Phone	**Preferred Reporting Method:** ☐ Email ☐ SecureDocs ☐ Fax
Referral Contact Supervisor Name (If applicable):	

CLAIMANT INFORMATION

First Name:	**Last Name:**
Address:	**DOB:**
Home Phone: **Cell Phone:**	**Gender:** ☐ Male ☐ Female ☐ Other
Email:	**Elimination Period:**
Last Day Worked:	**First Day Absent:**
LTD Eligible? ☐ Yes ☐ No ☐ N/A	**If yes, provide LTD Date:**
Category Type: ☐ Occupational Illness ☐ Non-Occupational Illness ☐ N/A	
Contact employer prior to contacting employee? ☐ Yes ☐ No	

VOCATIONAL INFORMATON

Occupation:	**Manager:** **Email:** **Phone:** **EXT:**
Address:	**Group Type:** ☐ Union ☐ Non-Union
Employee Work Phone: **EXT:**	**Date of Hire:**
Employment Type: ☐ Full-time ☐ Part-time ☐ Contract	**Employee's Department/ Group Type:**

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SERVICE(S) REQUESTED (Check one or more):

Disability Leave Management	Specialized Programs & Services	Vocational Services	Rehab Case Management
☐ STD/WI/Sick Leave/Salary Continuance ☐ Accommodation Review ☐ Attendance Management ☐ Ergonomic Assessment ☐ Customized Team Training (i.e. Sensitivity training – half day, Mental Health in the Work Place, Resiliency and Fatigue Management, etc.)	☐ Customized Reactivation ☐ Progressive Goal Attainment Program ☐ Cognitive Job Coaching ☐ Functional Job Coaching ☐ Physical Demands Analysis ☐ Cognitive Demands Analysis ☐ Ergonomic Assessment ☐ Functional Ability Evaluation ☐ Cognitive Ability Evaluation	TSA: ☐ Telephonic ☐ File-based ☐ Vocational Assessment ☐ Psycho-Vocational Assessment ☐ Job Search Training ☐ Supported Job Search ☐ Labour Market Survey Computer Fundamentals: ☐ Basic (4 wk) ☐ +Excel (6 wk)	☐ Standard Initial Assessment Enhanced Assessment: ☐ Cognitive Screening ☐ Psycho-Social Screening ☐ Pharmacogenetic Testing ☐ RTW Coordination ☐ Customized Request (note below)
Customized Request:			

SPECIAL INSTRUCTIONS & ADDITIONAL INFORMATION

Interpreter Required: ☐ Yes ☐ No	**First Language:**
Assessment to be conducted in: ☐ English ☐ French	**Report to be written in:** ☐ English ☐ French

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ENCLOSED DOCUMENTS (Check all that apply):

☐ Signed Consent Form
☐ Relevant medical documents
☐ Job Description/ PDA (If available)
For TSA (Transferable Skills Analysis), Vocational Assessments and Psycho-Vocational Assessments, please provide: ☐ Commensurate hourly wage range ☐ Current physical and/or cognitive restrictions & limitations ☐ Education ☐ Employment history If available: ☐ Resume ☐ Job description ☐ Physical Demands Analysis

Has your claimant/ employee/ client/ plan member been advised about this referral? ☐ Yes ☐ No

Please contact us at info@agsrehab.com for a complimentary consultation if you have questions or require assistance.

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.