

REFERRAL FORM – OCCUPATIONAL REHABILITATION SERVICES

Claimant Detail

Name: _____

Address: _____
_____ P/Code _____

Contact Number: _____

Date of Birth: _____ M F

Agent Details

Agent: _____

Contact Person: _____

Address: _____
_____ P/Code _____

Contact Number: Tel. _____
Fax. _____

Email Address: _____

Claim Number: _____

Claim Accepted Not Determined

Nature of Injury: _____

Date of Injury: _____

Occupation: _____

Interpreter Req'd: (specify language) _____

Employer Details

Company Name: _____

Contact Person: _____

Address: _____
_____ P/Code _____

Contact Number: Tel. _____
Fax. _____

Email Address: _____

Treating Practitioner Details

Doctor: _____

Address: _____
_____ P/Code _____

PROGRAM SERVICES REQUIRED

RTW Services

- Occ. Rehab. (ORO2) Same Employer Services
- Occ. Rehab. (OR03) Diff. Employer Services
- Initial Assessment Only
- Early Intervention Assessment
- Return to Work Program
- Workplace Assessment

Vocational Services

- Vocational Assessment
- Vocational Counseling
- Retraining assistance
- Job Placement

Specialist Assessment Services

- Section 40 Assessment
- Functional Capacity Evaluation
- Vocational Assessment
- Stress Assessment (Factual)
- Psychological Assessment
- ADL
- Other

Approved by: Name: _____

Title: _____

Date: ___/___/___

Company: _____ Signature: _____

Send Invoice to: Agent Employer