**CLIENT REFERRAL FORM**

|  |
| --- |
| **CLIENT INOFRMATION:** |
| Name of client:  |  |
| Date of Birth:  | Gender: |
| Email: | Phone: |
| Address: |
| **CLIENT MEDICAL HISTORY:** |
| Current diagnosis:  |
| Reasons for referral (Please tick all that apply):[ ] MVA injury [ ] Personal injury [ ] Stroke [ ] post-surgery [ ] Concussion [ ] Chronic pain [ ] Fibromyalgia [ ] Genetic/Congenital disorder [ ] Age [ ] Dementia [ ] Alzheimer’s [ ] Mental health[ ] Other: |
| Date of loss/ injury (if applicable): |
| **LAW FIRM INFORMATION (if applicable):** |
| Law Firm:  | Lawyer name: |
| Email: | Phone: Fax: |
| **INSURANCE INFORMATION (if applicable):** |
| Company name:  | Branch: |
| Adjuster name: | Adjuster email: |
| Adjuster phone: | Adjuster fax: |
| Policy holder: | Claim number: Policy number: |
| **OCCUPATIONAL THERAPIST INFORMATION (if applicable):** |
| Name of provider:  | Organization: |
| [ ] AC Report/Form 1 attached [ ]  Form 1 funding available: |
| **SERVICES REQUESTED** |
| [ ] Personal Support Services: Virtual | [ ]  Personal Support Services: In-person |
| [ ] Interpreter/translation service | [ ]  OCF 18 Rehabilitation Support Services - Virtual |
| **REFERRER’S DETAILS** |
| Name:  | Title: |
| Organization: | Email: |
| Phone: | Fax: |
| **Signature:** | **Date:** |