



Referral Form Employer Services

Workplace Wellness and Injury Prevention
Occupational Therapy Services
Functional Evaluation
Disability Management
Vocational Services

Referring Agency: _____
Address: _____

Phone: _____ Fax: _____
E-Mail: _____
Contact Person: _____

Employer: _____
Address: _____

Phone: _____ Fax: _____
E-Mail: _____
Contact Person: _____

Client: _____ Claim/File Number: _____
Address: _____
Phone: _____ Date of Birth: _____ Occupation: _____
Date of Injury/Illness: _____ Diagnosis: _____

Physician: _____
Address: _____

Phone: _____ Fax: _____
E-Mail: _____

Legal Rep: _____
Address: _____

Phone: _____ Fax: _____
E-Mail: _____

Please select the appropriate Service

- Post Hire Screening
- Disability Management Program Development
- Disability Management Program Auditing
- Return to work Coordination
- Workplace Accommodations
- Job Analysis
- Functional Capacity Evaluations
 - General
 - Job Specific
 - One-day
 - Two-day

- Occupational Ergonomics
- Workplace Health and Wellness
- Case Management
- Accessibility Assessment
- Occupational Physiotherapy
- Job Comparison Report
- Training
 - _____

Special Instructions: _____

