

REFERRAL



Client name: _____
Claim #: _____
Date of birth: _____
Occupation: _____
Date of injury/illness: _____
Last worked: _____
Address: _____
Telephone: _____

Referring agent: _____
Agency: _____
Telephone: _____
Fax: _____

Employer contact info: _____

Family doctor: _____

State any questions you wish to have answered from this referral:

- Physiotherapy: _____
- Acupuncture (Physio): _____
- Chiropractic: _____
- Massage Therapy: _____
- Team Assessment: _____
- Custom Orthotics: _____

Occupational Therapy:

- | | |
|--|---|
| <input type="checkbox"/> Functional Capacity Evaluation | <input type="checkbox"/> Job Site Analysis |
| <input type="checkbox"/> Targeted Functional Assessment | <input type="checkbox"/> Work Station Review/Ergonomic Assessment |
| <input type="checkbox"/> Work Hardening (Clinic based Occ. Rehab.) | <input type="checkbox"/> Injury Prevention Program |
| <input type="checkbox"/> Work Conditioning (Clinic based Occ. Rehab.) | <input type="checkbox"/> Health Seminars |
| <input type="checkbox"/> Easeback Program & Monitoring (Worksite OR) | <input type="checkbox"/> Accessibility Assessments |
| <input type="checkbox"/> Job Match | <input type="checkbox"/> Wheelchair Assessments |
| <input type="checkbox"/> Back Strengthening & Stabilization Program | <input type="checkbox"/> ADL Assessment |
| <input type="checkbox"/> Neck & Shoulder Strengthening & Stabilization Program | <input type="checkbox"/> Other: |

Cowan Heights Area
179 Hamlyn Rd,
St. John's NL A1E 5Z5
Tel: 709.747.5945
Fax: 709.747.5946

Upper Level of
Lawton's Drugstore
496 Tosail Rd.,
St. John's NL A1E 5Z5
Tel: 709.745.5945
Fax: 709.745.5946

Solutions for Soft Tissue Injuries

Please provide any relevant documentation or additional information you feel will be of benefit.

Signature:

Date: