REFERRAL FORM

***Fax to* (709) 747-5946**

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St. John's, NL
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Ph (709) 747-5945
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496 Topsail Road - Suite 202
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A Dedicated Team of Experienced Health Professionals
Physiotherapy • Occupational Therapy • Chiropractic • Massage Therapy • Psychology
www.inmotionhealthcentre.ca

Client Information
Name: _____
Address: _____
Phone: _____
Claim #: _____
Date of Birth: _____
Occupation: _____
Date of Injury/Illness: _____
Last day worked: _____
Family Doctor: _____

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

_____

_____

Referral Agent Information
Referring Agent: _____
Phone: _____
Contact Name: _____
Address: _____
Email Address: _____

Employer Information *(if applicable)*
Name: _____
Address: _____
Contact Name: _____
Phone: _____

Physiotherapy: ☐ _____
Acupuncture (Physio): ☐ _____
Chiropractic: ☐ _____
Massage Therapy: ☐ _____
Psychology ☐ _____
Team Assessment: ☐ _____
Independent Assessment PT ☐ DC ☐ OT ☐ Psych ☐ RMT ☐
Custom Orthotics: ☐ _____

Occupational Therapy:

☐ Functional Capacity Evaluation (FCE)
☐ Targeted Functional Assessment (TFA)
☐ Functional Assessment (FA)
☐ Pre-Employment Screening
☐ Ergonomic Assessment / Work Station Review
☐ Work Hardening (Clinic based Occ. Rehab)
☐ Work Conditioning (Clinic based Occ. Rehab)
☐ Job Match
☐ Easeback Program & Monitoring (Worksite OR)
☐ Concussion Assmt and Management (***SHIFT***)
☐ Job Site Analysis (JSA)
☐ Progressive Goal Attainment Program (***PGAP***)
☐ Reactivation Program (Psychology and OT)
☐ Health Education Presentation
☐ Accessibility Assmt/ Wheelchair Assmt
☐ ADL Assessment
☐ Back Core Stabilization Program (One-on-one)
☐ Neck/Shoulder Stabilization Program (One-on-one)
☐ Pediatric Assessment - Treatment
☐ **Other**: _____

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

Signature: _____ Date: _____