REFERRAL FORM

Fax to (709) 747-5946

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St. John's, NL
A1E 5Z5
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: ______________________________
Injury: ______________________________
Date of Injury/Illness: ______________________________
Last day worked:______________________________
Family Doctor: ______________________________

Referral Agent Information

Referring Agent: ______________________________
Phone: ______________________________
Company: ______________________________
Address: ______________________________
Email Address: ______________________________

Employer Information *(if applicable)*

Company:______________________________
Address: ______________________________
Contact Name: ______________________________
Phone: ______________________________

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

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

Occupational Therapy:

Functional Assessments:

☐ Functional Capacity Evaluation (FCE)
  ☐ 1 day   ☐ 2 day
☐ Functional Scan Intake Assessment
☐ Functional Assessment (FA)

Cognitive Assessments and Rehab / BrainFit:

☐ Cognitive Functional Assessment
☐ Cognitive Job Site Analysis
☐ Cognitive Behavioural Therapy (**CBT**)
☐ Concussion Assessment and Management
☐ Brain FX Assessment
☐ Reactivation Program (Psychology and/or OT).
☐ Progressive Goal Attainment Program (***PGAP***)

☐ **Other**: ______________________

Clinic Rehabilitation (Physical):

☐ Exercise Gym Strengthening Program
☐ (CBOR) Clinic Based Occupational Rehab
☐ Work Conditioning/Hardening
☐ Back Core Stabilization Program (One-on-one)

Worksite Assessments:

☐ (Worksite OR) Ease Back to Work Program
☐ Ergonomic Assessment / Work Station Review
☐ Job Site Analysis (JSA)
☐ Job Match
☐ Pre-Employment Screening

Home Assessments:

☐ Accessibility Assmt/ Wheelchair Assessment
☐ ADL Assessment
☐ Future Cost of Care Assessment

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

Signature: ______________________________ Date: ______________________

This fax may contain private and confidential information. Should you receive this by error, we would appreciate it if you would telephone us to advise us and then destroy this information. Thank-you very much.