Skill Builders
PHYSIOTHERAPY & REHABILITATION CENTRE

Physiotherapy
Occupational Therapy
Dizziness Treatment
Serious Injury Rehab
Massage Therapy
Sports Injury Treatment
Brain Injury & Stroke Rehab
Driver Evaluation & Training

REFERRAL FORM

Client Information

Client Name: _____ Date of Birth: _____

Address: _____

Home ☎: _____ Alternate ☎: _____

Email: _____ Date of Loss: _____

Injury & Functional Issues Summary: ☐ MVA ☐ WSIB ☐ Other: _____

_____

_____

Document Summary

Type of Additional Documents on file (if any): _____

Documents will be sent via: ☐ Fax ☐ Mail ☐ Email ☐ Other: _____

Type of Assessment(s) Required

Occupational Therapy

☐ In-Home ☐ Cognitive ☐ Attendant Care ☐ Functional
☐ Assistive Device ☐ PGAP Program ☐ Work Site Demands ☐ Life Care Planning
☐ Pre-Claim ☐ Med-Rehab ☐ Independent Evaluation

Other

☐ Physiotherapy ☐ Massage Therapy ☐ Psychology ☐ Driving Evaluation

Billing / Third Party / Insurance Information

Company: _____

Address: _____

☎: _____ Fax: _____

Policy #: _____ Claim #: _____

Adjustor: _____ HCAI Branch: _____

Extended Health Benefits? ☐ Yes ☐ No

If Yes, Provider/Group#/Policy#: _____

Other Professionals

Family Physician: _____ Specialist: _____

Other: _____

_____

Referral Information

Referred by: _____ Date of Referral: _____

Company: _____ Fax: _____

☎: _____ Email: _____

Office Use Only: Appt. Date: _____ Time: _____ Therapist: _____

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