PRIMARY HEALTHCARE FOR
INJURY RECOVERY

Skill Builders | PHYSIOTHERAPY & REHABILITATION

PHYSIOTHERAPY
OCCUPATIONAL THERAPY
MASSAGE THERAPY
DIZZINESS CLINIC
CONCUSSION REHAB
NEURO THERAPY - BRAIN & STROKE
MEDICAL DRIVING ASSESSMENTS

REFERRAL FORM *for* THIRD PARTY BILLING

Client Information

Client Name: _____ Date of Birth: _____
Address: _____
Contact No. ☏: _____ Email: _____
Date of Loss: _____ Injury related to: ☐ MVA ☐ WSIB ☐ Other

Service(s) Required

☐ Physiotherapy ☐ Occupational Therapy ☐ Dizziness Clinic ☐ Driving Evaluation
☐ Massage Therapy ☐ Concussion Rehab ☐ Custom Bracing ☐ Custom Splinting

Diagnosis/Comments/Precautions: _____
_____
_____

Billing / Third Party / Insurance Information

Company: _____
Address: _____
Contact Person/Adjustor: _____
Contact No. ☏: _____ Fax: _____
Email: _____ Claim No.: _____
Policy No.: _____
Extended Health Benefits: ☐ YES ☐ NO
If Yes, Provider /Group # / Policy #: _____

Referral Information

Referred By: _____ Date of Referral: _____
Company: _____
Address: _____
Contact No. ☏: _____ Fax: _____