

# Treatment Referral Form

Referral Date: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Claimant			
Surname		First Name ( <i>Mr., Mrs., Ms., Miss</i> )	
Address		Job Title	
City	Postal Code	Telephone ( )	Date of Birth D/M/Y
Injury Date	D/M/Y	Language Barrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Referred By:	
Surname	First Name
Address	Telephone ( ) Facsimile ( )
Title	Email Address:

Family Doctor:	
Name	Telephone ( ) Facsimile ( )
Address	

Funding Information:	
Company Name	Contact Person
Address	Telephone ( ) Facsimile ( )

Lawyer:	
Company Name	Contact Person
Address	Telephone ( ) Facsimile ( )

Nature of Problem/Goals/Special Issues:	

<b>Medical Information</b> <input type="checkbox"/> Faxed <input type="checkbox"/> Mailed	<b>Job Description</b> <b>Work Status</b>	<input type="checkbox"/> Faxed <input type="checkbox"/> Part Time	<input type="checkbox"/> Mailed <input type="checkbox"/> Not Working
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Please fax this form to either one of our locations:

**Toronto Clinic**   
 36 York Mills Rd., Suite 110  
 Toronto, Ontario M2P 2E9  
**Yonge & York Mills, Bldg. #1**  
 Tel: (416) 226-4722  
 Fax: (416) 226-9611

**Mississauga Clinic**   
 2155 Leanne Blvd, Suite 118  
 Mississauga, Ontario L5K 2K8  
**QEW & Erin Mills Parkway**  
 Tel: (905) 855-1807  
 Fax: (905) 855-2825