

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 mm/dd/yyyy
Injury Date mm/dd/yyyy		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:	

Medical Information <input type="checkbox"/> Faxed <input type="checkbox"/> Mailed	Job Description Work Status	<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