

Programs accredited by CARF

At Health Recovery our goal is to provide clients with the utmost quality of care. To assist us in ensuring that this goal is accomplished, please complete all of the following information and enclose the relevant documents with your referral.

**Referral Date:**

**Claim Number:**

### Claimant Information

Surname	First Name (Mr., Mrs., Ms., Miss)	
Address	City	Postal Code
Home Telephone	Cell/Other Telephone	
Injury Date & Area (s) <small>dd/mm/yy</small>	DOB <small>dd/mm/yy</small>	
Language Barrier? <input type="checkbox"/> No <input type="checkbox"/> Yes → If yes, please indicate language		

### Referred By

Surname	First Name	
Address	City	Postal Code
Telephone	Facsimile	
Sector	Title	
Current Barrier(s) <input type="checkbox"/> Pain <input type="checkbox"/> Endurance <input type="checkbox"/> Psychological → <input type="checkbox"/> Please perform a psychological assessment <input type="checkbox"/> Medical → Please perform a medical assessment (specify field):		
Treatment Goal <input type="checkbox"/> RTW AE Full <input type="checkbox"/> RTW AE Modified <input type="checkbox"/> RTW other <input type="checkbox"/> LMR <input type="checkbox"/> QTY (Improve Quality of Life)		
Comments/Concerns		

### Family Doctor

Surname	First Name	
Address	City	Postal Code
Telephone	Facsimile	
Medical Documents Available? <input type="checkbox"/> No <input type="checkbox"/> Yes → If yes, please indicate type <input type="checkbox"/> MRI <input type="checkbox"/> CAT <input type="checkbox"/> X-Ray <input type="checkbox"/> Reports		

### Employer

Company	Contact Person	
Address	City	Postal Code
Telephone	Facsimile	
Claimant's Position <input type="checkbox"/> Not Working <input type="checkbox"/> Working: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Full <input type="checkbox"/> Modified		
Is this job available? <input type="checkbox"/> No <input type="checkbox"/> Yes → If yes, is there a JDA available? <input type="checkbox"/> No ↓ <input type="checkbox"/> Yes → If yes, please forward		
If no JDA is available, are you willing to have one completed? <input type="checkbox"/> No <input type="checkbox"/> Yes → By: <input type="checkbox"/> WSIB <input type="checkbox"/> Health Recovery		

**Please fax this form with any relevant information to one of the following clinic locations:**

Toronto Clinic: Yonge & York Mills Road <input type="checkbox"/> 36 York Mills Road, Suite 110 Toronto, ON M2P 2E9 Tel: 416-226-4722 Fax: 416-226-9611	Mississauga Clinic: QEW & Erin Mills Parkway <input type="checkbox"/> 2155 Leanne Blvd., Suite 118 Mississauga, ON L5K 2K8 Tel: 905-855-1807 Fax: 905-855-2825
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