



North York
Rehabilitation
Centre Referral Form

MULTIDISCIPLINARY HEALTH CARE

CELEBRATING 15 YEARS OF SERVICE

Fax Number:

(416) 497-4662

Insurance Company Information:

Adjuster Name:

Title:

Company:

Address:

Telephone Number:

Extension:

Fax Number:

E-mail Address:

Claim/File Number:

Date of Loss:

Legal Representative Information (if applicable):

Representative's Name:

Company:

Address:

Telephone Number:

Fax Number:

Email Address:

Claimant Information:

First Name:

Surname:

Gender:

Date of Birth:

Address:

Telephone Number:

Business Number:

Email Address:

Translator Required:

Language:

Approval given to arrange Interpreter:

Transportation Required:

Approval given to arrange Transportation:

Employment Information:

Employer:

Job Title:

Contact Person:

Telephone Number:

Fax Number:

E-mail Address:

Family Physician/Health Practitioner Information:

Name:

Address:

Telephone Number:

Fax Number:

Treating Facility Information:

Treatment Provider Name:

Facility Name:

Address:

Telephone Number:

Fax Number:

Diagnosis:

Benefits to be addressed:

- Income Replacement Benefits
 - Employed
 - Unemployed
 - Post – 104 Week Disability
- Non-Earner Benefits
 - Caregiving
 - Housekeeping/Maintenance
 - Medical Rehabilitation
 - Other _____
 - Other _____

Examination Type(s)

- Attendant Care/Form 1
- In-Home Assessment
- Pre-Claim Examination
- Functional Abilities Evaluation
- Treatment Plan dispute
- Other: _____
- Catastrophic Impairment
- Application for Assessment/OCF-22
- PAF Disputes/OCF-22 Direct
- TBI/Catastrophic or Case Management
- Duplicate Treatment Plan Dispute
- Other: _____

Assessment(s) Required:

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopaedic Surgeon |
| <input type="checkbox"/> Psychologist | <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Neuropsychologist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Oral Surgeon | <input type="checkbox"/> Urologist |
| <input type="checkbox"/> Registered Nurse | <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Medical Physician |
| <input type="checkbox"/> Psychiatrist | | <input type="checkbox"/> Occupational Therapist |
| | | <input type="checkbox"/> Physiotherapist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Other: _____ | | |

At discretion of Intake/North York Rehabilitation Centre

Is this a re-assessment? ____

Dates of assessments must be arranged during what time period to ensure SABS compliance:

Additional Notes:
