EXCEL MEDICAL
DIAGNOSTICS

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REFERRAL FORM

PATIENT INFORMATION

Date of Loss:	Last:	First:	Middle:
Sex:	Birth Date:	Home Phone #:	Cell Phone #:
Street Address:	Apt. #:	City:	Province:
Postal Code:			

INSURANCE INFORMATION

Company Name:	Policy:	Claim:	Date of Loss:
Adjuster Name:	Telephone:	Fax:	

LEGAL REPRESENTATIVE

Company Name:	Lawyer:	Clerk/Assistant:	Telephone:
Fax:	E-mail:		

REFERRAL INFORMATION

Name:	Telephone:	Fax:	E-mail:

Interpreter required: Yes ☐ No ☐

If Yes, What Language ____________________

AB: ☐ **TORT:** ☐

Medical Brief: Faxed ☐ Mailed ☐ Couriered ☐

Report due by: ____________________

Questions to be addressed: Yes ☐ No ☐

- ☐ CASE MANAGEMENT (OT, RN)
- ☐ HOSPITAL DISCHARGE PLANNING
- ☐ HOME SAFETY
- ☐ HOME ACCESSIBILITY
- ☐ ATTENDANT CARE, FORM 1
- ☐ HOME MEDICAL EQUIPMENT
- ☐ HOME MODIFICATIONS
- ☐ VEHICLE MODIFICATION
- ☐ JOB SITE/ERGONOMIC
- ☐ FUNCTIONAL ABILITIES EVALUATION (FAE)
- ☐ PHYSICAL DEMAND ANALYSIS
- ☐ EMG/NCS
- ☐ MRI
- ☐ CT SCAN
- ☐ SLEEP DISORDER STUDY
- ☐ REHABILITATION SUPPORT WORKER (RSW)
- ☐ NURSING
- ☐ PERSONAL CARE (PSW)
- ☐ COMPANION/HOUSEKEEPING
- ☐ CHRONIC PAIN MANAGEMENT PROGRAM
- ☐ DRIVING INTEGRATION PROGRAM
- ☐ VOCATIONAL REINTEGRATION PROGRAM
- ☐ WORK HARDENING PROGRAM
- ☐ WEIGHT LOSS PROGRAM
- ☐ EXPERT FILE REVIEW
- ☐ OTHER
- ☐ CATASTROPHIC IMPAIRMENT
- ☐ CHRONIC PAIN
- ☐ DENTAL/TMJ
- ☐ FUTURE CARE COST
- ☐ LOSS OF EARNING
- ☐ NEUROLOGY
- ☐ NEUROPSYCHOLOGY
- ☐ NEUROPSYCHIATRY
- ☐ NEUROSURGERY
- ☐ OPHTHALMOLOGY
- ☐ OPTOMETRIST
- ☐ ORAL SURGERY
- ☐ ORTHOPAEDIC SURGEON
- ☐ OTOLARYNGOLOGY (ENT)
- ☐ PHYSIATRY
- ☐ PHYSICIAN(GP)
- ☐ PLASTIC SURGERY
- ☐ PSYCHIATRY
- ☐ PSYCHO-EDUCATIONAL
- ☐ PSYCHO-VOCATIONAL
- ☐ RHEUMATOLOGY
- ☐ SOCIAL WORK
- ☐ SPEECH-LANGUAGE PATHOLOGY
- ☐ VOCATIONAL
- ☐ TRANSFERABLE SKILLS ANALYSIS