

WORK ABILITIES LTD.
REFERRAL REQUEST FORM

Please Print Clearly

Plaintiff Defence

REFERRING AGENCY: _____ Date: _____

Referring Agent: _____ Phone: _____

Address: _____ Fax: _____

CLIENT NAME: _____ Birth Date: _____

Client Address: _____ Phone: _____

_____ Alt Phone: _____

Client E-mail: _____ Claim/File #: _____

Accident/Illness onset Date: _____ Details of Injury/Illness: _____

Client's Physician: _____

Client's most recent/current Employer: _____ Client's job title: _____

Client's pre-injury/illness Employer: _____ Client's job title: _____

QUESTIONS: NB. PLEASE TAKE THE TIME TO COMPLETE THIS SECTION.

1. Do Work Abilities Staff have permission to discuss the results of the evaluation with the client? _____
2. Have you included all the available information (e.g. job descriptions, work site analysis, medical reports)? _____
3. Does the client require the services of a translator? _____ Who is to arrange for translator? _____ What language: _____

INDEPENDENT FUNCTIONAL EVALUATIONS (choose from the following questions and services)

- What are the client's current functional capacities **relative to the job demands in question?**
- Given the client's performance over the course of the evaluation, his/her injuries/illness, and his/her perceived pain management skills, would he/she benefit from participating in rehabilitative programs?
- What restrictions would have to be accommodated or interventions, if any, would be required to return the client to competitive employment?
- Other: _____

OTHER ASSESMENTS AND SERVICES (Please select any other assessments and or services you will require.)

- Loss of Housekeeping Cost of Future Care Work Site Analysis Work Visit Home Visit

WORK CAPACITY EVALUATIONS (choose from the following questions)

- What are the client's current **general work capacities?**
- Given the client's performance over the course of the evaluation, his/her injuries/illness, and his/her perceived pain management skills, would he/she benefit from participating in rehabilitative programs?
- What restrictions would have to be accommodated or interventions, if any, would be required to return the client to competitive employment?
- Other: _____

Payment Information:

- * Account is due upon receipt of invoice.
- * Referral Agent's signature authorises Work Abilities Ltd. to proceed with the services requested and represents an undertaking to pay for the requested service(s) within 30 days of receipt of the invoice.

NB. Cancellation with insufficient notice (**i.e. at least 2 working days prior to the appointment time**) will result in the referral source being billed up to \$960.00 depending on the assessment booked.

No shows will result in the referral source being billed for the full amount of the assessment.

Signature of Referral Agent _____