

REQUEST FOR SERVICE (Customer Form)

Submit by Fax to 416 – 927-8677.

Note: Email version is available by calling 416 – 927 – 1614.

DATE OF REFERRAL:

DATE OF LOSS:

A) REFERRAL SOURCE

Preferred Date Format: Day Month Year;

Name Format: First then Last.

| | | |
|---------------------------|--------------|----------------------------|
| Company Name: | | |
| Street Address: | City: | Province: |
| Postal Code: | Company Tel: | Company Fax: |
| Contact Person: | Direct line: | E-mail: |
| Alternate Contact Person: | | Alternate Contact Phone #: |
| File No / Claim No: | Policy #: | Name of Policy Holder: |

B) PRINCIPAL INSURER (If different from referral source)

| | | |
|--|-------------|---------|
| Company Name: | | |
| Address: | Claims Rep: | |
| Tel: | Fax: | E-mail: |
| Who is to be invoiced? Principal <input type="checkbox"/> Referral Source <input type="checkbox"/> | | |
| Principal to get copies of reports? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

C) CLIENT INFORMATION

| | | |
|--|----------------|-----------|
| CLIENT NAME: | | |
| Home Address (full): | | |
| Home Phone: | | |
| Alternate Contact (Name, Relationship and Phone #): | | |
| Current Location of Client: Home <input type="checkbox"/> Hospital <input type="checkbox"/> Other <input type="checkbox"/> | | |
| Male <input type="checkbox"/> Female <input type="checkbox"/> | Date of Birth: | |
| Occupation: | Address: | Work Tel: |
| Interpreter required?: Yes <input type="checkbox"/> No <input type="checkbox"/> Language: | | |
| LEGAL REPRESENTATIVE INFORMATION | | |
| If not already referenced please complete: Company Name: | | Lawyer: |
| Address: | Phone: | Fax: |

D) INJURY INFORMATION / FUNCTIONAL LIMITATIONS

| |
|---|
| Description of Injury / Functional Limitations: (Notes) |
| |
| |

E) SERVICE INFORMATION

| | |
|---|---|
| Reason for referral: (Details) | |
| | |
| | |
| Sec 42: <input type="checkbox"/> Sec 24: <input type="checkbox"/> | OCF form required: <input type="checkbox"/> Client Signature required: <input type="checkbox"/> |
| Medical Records to be forwarded: <input type="checkbox"/> | Date report needed? |