Career Shift

REFERRAL FORM

INJURED WORKER

Name: Telephone:

Address:

D.O.B: D.O.I.:

Job Title/Occupation: Nature of injury:

Interpreter Needed: Yes/No Language:

EMPLOYER

Employer: Worksite Location:

Address:

Supervisor / RTW Coordinator: Email:

Phone: Fax:

Employment Status: At Work ▫ Off work ▫ Terminated ▫

INSURER

Insurer: IMA: Case Mgr:

Telephone: Fax: Email:

Address:

Claim Number: Liability Accepted: Yes/No/Don't know

TREATING DOCTOR/OTHER

Name: Telephone:

Address:

Email: Fax:

SERVICE

- ▫ Case Management (Same) / Redeployment
- ▫ Functional Assessment
- ▫ Workplace Assessment
- ▫ Vocational Assessment
- ▫ ADL Assessment / Consultation
- ▫ NTD / Case Conference / Consultation
- ▫ Job Task Analysis
- ▫ Functional Screening
- ▫ Psychological Injury Assessment (Stress)
- ▫ Psychological Assessment/Counselling
- ▫ Claims Review Intervention
- ▫ Ergonomic Assessment
- ▫ Medico-legal Assessment
- ▫ Job Seeking / Placement Services
- ▫ Quick Start Assessment
- ▫ Other (Specify)

REFERRAL SOURCE

Name: Telephone:

Company: Email:

Fax: Signature:

Date: