



BACK ON TRACK EXTERNAL REFERRAL REQUEST

Referrals Coordinator: (416) 226-6780 ext. 6949

Please fax referral to: (416) 224-6968

Applicant Information	Last Name:		First Name:		Gender: Male <input type="radio"/> Female <input type="radio"/>	
	Address:			City:		Province:
	Postal Code:		Telephone #: ()		Alternate #: ()	
	DOB:		Next of Kin:		Telephone #: ()	
	Requires Interpreter: No <input type="radio"/> Yes <input type="radio"/> Language:					

Insurance Information	<input type="radio"/> W.S.I.B		<input type="radio"/> M.V.C		
	Claim #:		Claim #:		
	Case Manager:	Telephone #: ()		Company Name:	
		Fax #: ()			
	Nurse Consultant:	Telephone #: ()		Adjuster Name:	
		Fax #: ()		Telephone #:: ()	
				Fax #: ()	
		Fax #: ()		Rehab Consultant:	
	Telephone #: ()				
	Fax #: ()		Fax #: ()		
Telephone #: ()					
Extended Health Insurance Information: Is there other insurance coverage for any goods and services required for treatment? <input type="radio"/> No <input type="radio"/> Yes					
Name of Insurance Provider:		Name of Employer:		Group Number:	
Subscriber's Name:		Subscriber's Number:		Relationship to Subscriber:	

Referral Information	Medical Clearance for Rehabilitation: <input type="radio"/> Yes <input type="radio"/> No <i>*Please attach supporting documentation</i>		
	Physician Name:		
	Phone #: ()		Fax #: ()
	Diagnosis:		
	Supporting Documentation for Diagnosis attached: <input type="radio"/> No <input type="radio"/> Yes <i>Diagnostic Reports, Surgical Report, Medical Discharge Summary, Physician Clearance Order, Emergency note, etc.</i>		
	Date of Loss:		Precautions/Contra-Indications:
	Weight Bearing Status on: Lower Extremity: <input type="radio"/> Left <input type="radio"/> Right		
	Upper Extremity: <input type="radio"/> Left <input type="radio"/> Right		
Medical Specialists:			
<input type="radio"/> Burns <input type="radio"/> Amputees <input type="radio"/> Trauma/Physiatry			
<u>Services Requested:</u>			
<input type="radio"/> Physiotherapy <input type="radio"/> Occupational Therapy <input type="radio"/> Social Work <input type="radio"/> Nursing			
<input type="radio"/> Speech Language Pathology <input type="radio"/> Chiropody (non high risk) <input type="radio"/> Massage Therapy			
<input type="radio"/> Chiropractic <input type="radio"/> Acupuncture <input type="radio"/> Return to Work Coordinator <input type="radio"/> Psychology/Neuropsychology			
Physician Specialist:		Telephone #: ()	Fax #: ()
Physician Specialist:		Telephone #: ()	Fax #: ()

Referred By	Agency/Hospital:		Name and Discipline:
	Telephone #: ()	Fax #: ()	Date:
	Has a follow up appointment been booked with the specialist? No <input type="radio"/> Yes <input type="radio"/> Date:		