PSYCHOLOGY HEALTH SOLUTIONS

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REFERRAL INFORMATION SHEET

Intake Information:

Referral Source: _____ Date of Referral: _____

Type of Referral: ☐ WSIB ☐ MVA ☐ Private ☐ Med/Legal

Concerns/Reason(s) for Referral:

Other notes: _____

Patient Name: _____ Date of Injury: _____

Address: _____ Date of Birth: _____

_____ Gender (M/F): _____

Email: _____ Phone: _____

Extended Health Benefits:

Policy Holder: _____ Claim #: _____

Group #: _____ Policy #: _____

Insurer Information (Auto):

Company: _____ Adjuster: _____

Address: _____ Claim #: _____

_____ Policy #: _____

Phone: _____ Policy Holder: _____

Fax: _____ Email: _____

WSIB:

Case Manager: _____ Program: _____

Nurse Consultant: _____ Claim #: _____

Legal Representation:

Name: _____ Firm: _____

Address: _____ Phone: _____

_____ Fax: _____

Law Clerk: _____ Email: _____

Family Physician:

Name: _____ Practice Name: _____

Address: _____ Phone: _____ Fax: _____

_____ Email: _____

Other Contact:

Name: _____ Company: _____

Address: _____ Phone: _____ Fax: _____

_____ Email: _____

Other Contact:

Name: _____ Company: _____

Address: _____ Phone: _____ Fax: _____

_____ Email: _____