OT Works!

REFERRAL REQUEST

Email: **referrals@ot-works.com**
Phone: **604.696.1066** ext 1000
Fax: **604.648.8078**

Request Information

Your Name*	
Your Email*	
Your Phone*	
Your FAX	
Your Relationship to Client	❑ GP ❑ Lawyer ❑ Insurer ❑ Client/family member ❑ Other:
Occupational Therapy Services Requested*	❑ Assessment (home / work / ergonomic) ❑ Rehabilitation: (choose one) ❑ Return to work ❑ Return to function ❑ Workplace accommodation ❑ Disability/Case management ❑ PGAP (Progressive Goal Attainment Program) ❑ AMPS (Assessment of Motor and Process Skills) ❑ Other (specify):

Client Information

Client Name*	
Client Claim / File #*	
Client Phone*	
Diagnosis/Injury*	
Client Address (or City if known)	
Date of Loss	
Date of Birth	

Other Party Information (if known or applicable)

	Name	E-mail	Phone
GP			
Lawyer			
Insurer			
Family member			
Other:			

Billing Information

Same as Requestor? *	YES / NO (if No, please complete the fields below)
Billing Contact Name	
Billing Contact Email	
Billing Contact Phone	
Mailing Address*	
Billing Contact FAX	
Relationship to Client*	❑ GP ❑ Lawyer ❑ Insurer ❑ Client/family member ❑ Other:

* = Required information. Please complete the fields indicate with a * to the best extent possible
Complete and return by e-mail: **referrals@ot-works.com** or by **Fax 604.648.8078**
Questions? Please call 604.696.1066 ext 1000

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