OT Works!

REFERRAL REQUEST

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

Referral Information

Your Name*			
Your Email*		**Your Phone***	
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 ❑ FCE (Functional Capacity Evaluation) ❑ CFC (Cost of Future Care assessment) ❑ PGAP (Progressive Goal Attainment Program) ❑ Other (specify):	
Reason for Referral (why is OT needed?)			
Contact Me for more information	❑ YES ❑ No		

Client Information

Client Name*			
Client Email*		**Client Phone***	
Client Address* (or City if known)			
Diagnosis/Injury*			
PHN (Provincial Health Number)			
Date of Loss		Date of Birth	

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:		

ICBC Claim

ICBC requires a GP note recommending Occupational Therapy after an MVA. Please include the GP referral for timely service. If you have a lawyer, please provide contact information.

Client Claim / File #*			
Lawyer Name		Lawyer Phone or Email	

* = 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

© 2022 OT Works! Ltd.