Sunnybrook
WORKING CONDITION PROGRAM

Referral Form

PATIENT IDENTIFICATION

CLIENT INFORMATION

Name (PRINT): _____ Date (YYYY/MM/DD):_____

Address: _____ City: _____ Province: _____ Postal Code:_____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Date of Birth (YYYY/MM/DD):_____ Sex: ☐ Male ☐ Female

Health Card:_____ Version Code:_____

Interpreter Required: ☐ Yes ☐ No Working Condition Program to arrange: ☐ Yes ☐ No

Language Spoken: _____ Occupation: _____

Related to: ☐ WSIB/WCB ☐ Motor Vehicle Collision ☐ Long Term Disability ☐ Other:_____

Date of Loss / Incident (YYYY/MM/DD): _____ File / Claim No.:_____

Area(s) of Concern: _____

REFERRAL SOURCE INFORMATION

Name:_____

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone: _____ Fax: _____

E-mail:_____ Signature:_____

COPY REPORT(S) TO (Please attach additional names on a separate sheet)

Name: _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone: _____ Fax: _____

BILLING INFORMATION ☐ Same as Referral Source

Care of: _____

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone: _____ Fax: _____

REQUEST FOR (Please Check)

Assessment

☐ Independent Medical Evaluation (IME)
- ☐ Orthopaedic ☐ Neurology ☐ Psychology ☐ Other: _____

☐ Multidisciplinary Orthopaedic Assessment (Orthopaedic Surgeon and Physiotherapist)
☐ Functional Abilities Evaluation (FAE)
☐ Ergonomic Assessment / Job Site Assessment
☐ Physical Demands Analysis (PDA)
☐ Pre and Post-Offer Employment Screening
☐ In-Home Assessment
- ☐ Attendant / Personal Care ☐ Caregiver ☐ Home Accessibility / Safety
- ☐ Housekeeping ☐ Non-Earner

☐ File Review

Treatment

☐ Occupational Therapy
☐ Physiotherapy
☐ Psychology
☐ Return to Work Services
☐ Work Conditioning/Hardening
☐ Job Coaching
☐ Hand and Wrist Splinting
☐ Orthotic Services

NOTE: Fax to 416-967-8579 and attach specific referral questions and/or special instructions on a separate sheet

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