NeuroTrauma Rehab
Allied Health Referral Form
Parkwood Institute, Main Building
Telephone: 519-685-4061
Fax: 519-685-4066
ntrinfo@sjhc.london.on.ca



Clear Form

* fields are mandatory

Client Information		
*Name:	Address:	City:
*Phone: Ext:	Alternate Phone: Ext.	*Date of Birth: mm/dd/yyyy
Languages Spoken:	Email:	
Contact Person (if client not person of first contact)		
Name:	Relationship to Client:	Phone:
*Name:	Company:	Email:
*Phone: Ext:	Fax:	Address:
Reason for Referral		
*Injury Date: mm/dd/yyyy	*Cause of injury (e.g. workplace injury, motor vehicle collision, other):	
*Diagnoses:		
*Current Presenting Difficulties:		
Suggestive Goals for Service Request:		
*Company Name:	*Policy #:	Claim #:
Adjuster Name:	Phone: Ext.	Fax:
Insurance Company Name:	Contract #:	Plan Member Name:
Relationship to Plan Member:	Plan Member Certificate Number:	

Legal (if not referral source)		
Firm Name:	Lawyer:	Phone: Ext.
Physician (if not referral source)		
Name:	Phone: Ext.	Fax:
Email:		
Medical History		
Relevant medical history (e.g. concussions, behavioural concerns, mental health diagnosis, etc.)		
Please fax relevant medical records/provider reports to 519-685-4066.		
Services/treatment received since injury (if any):		
☐ Physiotherapy	☐ Occupational Therapy	☐ Massage Therapy
☐ Chiropractor	☐ Social Work/Psychology	☐ Speech-Language Pathology
☐ Audiology	☐ Optometry	☐ Other:
Additional Comments:		