



**NeuroTrauma Rehab**

Allied Health Referral Form  
 Parkwood Institute, Main Building  
 Telephone: 519-685-4061  
 Fax: 519-685-4066  
 Toll Free: 866-484-0445

\* fields are mandatory

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

Legal (if not referral source)		
Firm Name:	Lawyer:	Phone: <span style="float: right;">Ext.</span>
Physician (if not referral source)		
Name:	Phone: <span style="float: right;">Ext.</span>	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.		
<b>Services/treatment received since injury</b> (if any):		
<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Social Work/Psychology	<input type="checkbox"/> Speech-Language Pathology
<input type="checkbox"/> Audiology	<input type="checkbox"/> Optometry	<input type="checkbox"/> Other:
Additional Comments:		