ROSS Rehabilitation

www.rossrehab.com

REFERRAL / INTAKE FORM

875 Main Street West, Unit 1, Lower Level
Hamilton, ON L8S 4P9
Phone: (905) 777-9838 | Fax: (905) 777-9058 | Email: ross@rossrehab.com

CLIENT INFORMATION

Name: Male ☐ or Female ☐

Address:

Phone:

D.O.B. (Date of Birth): D.O.I. (Date of Injury):

Translator Required? Yes ☐ or No ☐ (Include Language:)

Medical History (Brief):

SERVICES REQUIRED

Referral Type: ☐ Accident Benefits ☐ Medical Legal ☐ Other

Service Required: ☐ Occupational Therapy Services ☐ Vocational Services ☐ Physiotherapy Services ☐ Other

Legal Representative (Name, Address, Tel. No. and Fax No.):	Family Physician (Name, Address, Tel. No. and Fax No.):

INSURANCE CARRIER

Name - Adjuster:

Company:

Address:

Phone: Fax:

Claim #: Policy #:

Policy Renewal Date:

Is the Client the Policy Holder? ☐ (Yes) ☐ (No) Does the Client have Benefit Options? ☐ (Yes) ☐ (No)

If no, enter name of plan member & company name:

If services/benefits are provided by any other insurance company, please enter details below:

Insurance Company: Policy #: Group #:

Address:

REFERRAL SOURCE (Name, Address, Email, Tel. No. and Fax No.)

Please fax or email completed referral form to (905) 777-9058 or ross@rossrehab.com