Millard Health

PRINT

MH035A
SERVICE REQUEST

REFERRAL DATE _____ **YOUR FILE NO.** _____ *Millard file no.* _____

CLIENT INFORMATION

Name _____ Gender: ☐ Male ☐ Female

Street Address _____ City _____ Province _____ Postal Code _____

Phone: Home _____ Work _____ Date of birth _____ Personal health no. _____

Interpreter required: ☐ *yes* ☐ *no* *If yes, what language?* _____ *Millard to arrange translation svcs.:* ☐ *yes* ☐ *no*

REFERRAL INFORMATION *(who is making the referral and therefore paying for the services?)*

Name _____ Phone No. _____ Ext. _____ Fax No. _____

Company _____ Email _____

Street Address _____ City _____ Province _____ Postal Code _____

VOCATIONAL INFORMATION

Occupation _____ *Job description attached?* ☐ *yes* ☐ *no* *Physical Demands Analysis attached?* ☐ *yes* ☐ *no*

Job attached (Position to return to?): ☐ *yes* ☐ *no* *Currently working:* ☐ *yes* ☐ *no* *If yes, on* ☐ *modified* ☐ *regular duties*

MEDICAL INFORMATION

Date of Accident/Onset/Loss _____ Injuries/Illness/Diagnosis _____

Medical package faxed? ☐ *yes* ☐ *no* *If no, will be provided?* ☐ *yes* ☐ *no* _____

_____

SERVICE(S) REQUESTED

Assessment Services

☐ Medical Status Exam (MSE)
☐ Independent Medical Exam (IME)
☐ Gait Assessment
☐ Hand Assessment
☐ Ergonomic Assessment
☐ Neuropsychological Assessment
☐ Basic Functional Capacity Evaluation (BFCE)
☐ Comprehensive Functional Capacity Evaluation (CFCE)
☐ Post Offer Pre-Employment Screen (POPE)
☐ Traumatic Psychological Injury Screen
☐ Return to Work Planning Meeting (RTWPM)
☐ Mild Traumatic Brain Injury Assessment
☐ Other _____

Treatment Programs and Services

☐ Physiotherapy
☐ Hand Therapy
☐ Interdisciplinary Return to Work Program
☐ Complex Return to Work Program
☐ Brain Injury Program
☐ Traumatic Psychological Injury Program

If assessment recommends treatment or diagnostic testing: ☐ *proceed with recommendations* ☐ *obtain approval from referral source first*

Comments or specific questions to be answered/purpose of referral: *Referral source to provide questions:* ☐ *yes* ☐ *no* ☐ *attached*

_____

_____

_____

IS CLIENT AWARE OF REFERRAL? ☐ yes ☐ no **SOLICITOR INVOLVED?** ☐ yes ☐ no

WHO CONFIRMS WITH CLIENT? ☐ Millard Health ☐ referral source

If any issues, contact: ☐ *referral source* ☐ *other* _____

If Millard contacting client, should we advise anyone else of appointment? ☐ *yes* ☐ *no*

If yes, specify name and address _____

ACCOMMODATIONS *(if required)*

Is Millard Health to book accommodations? ☐ *yes* ☐ *no* *NOTE: Millard Health is not responsible for hotel expenses or any damages incurred by your client.*
☐ *You, as the referral source, acknowledge and accept all hotel expenses and damages incurred by your client.*

REPORTING: *Report will be sent to the referral source only*

PLEASE NOTE: Millard Health has a cancellation/no show policy. ☐ *I have reviewed the cancellation policy*

*BOOKING INFORMATION (**Millard Health use only**)*

Date confirmed with client _____ *Referral source advised:* ☐ *yes* ☐ *no* *Price quoted* _____

Services booked (type of service, date, time, resource) _____

_____

Millard Health, 131 Airport Road, Edmonton, AB, T5G 0W6, Phone: (780) 498-3200, Toll Free: (888) 498-9902, Fax: (780) 498-3254