

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
- Other _____
- 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

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) _____