



ALLIED-MED TRAUMA EVALUATIONS INC

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CONFIDENTIAL PATIENT REFERRAL FORM

CLIENT NAME:

Phone Number: (Home)

(Work)

Address:

Postal Code:

Date of Accident or Injury:

(DAY) / (MONTH) / (YEAR)

D.O.B.

(DAY) / (MONTH) / (YEAR)

Gender: M F

Insurance Company:

Claim #:

Policy#:

Adjuster:

Insurer's TEL

FAX:

Law Firm/Lawyer:

MEDICAL EVALUATIONS:

- Orthopaedic Surgery
- Physiatry
- Chronic Pain (Anaesthesia)
- Rheumatology
- Psychiatry
- Neuropsychiatry
- Neurology
- Neurosurgery
- Dentist/TMJ
- ENT Physician
- Plastic Surgery
- Sleep Study

- Other
- MRI (please specify region)

OTHER HEALTH CARE EVALUATIONS:

- FAE
- Vocational assessment
- Job-Site Analysis
- In-Home Assessment
- Future Cost of Care

NEUROPSYCHOLOGY EVALUATIONS:

- Neuropsychological
- Neuropsychvoc

PSYCHOLOGY EVALUATIONS:

- Psychological
- Psycho vocational
- Treatment plan

Interpreter required? yes no Language:

Medical Brief (required): Faxed Mailed Couriered

Tort file: yes no

OCF 18 (AB Treatment & Assessment Plan) required? yes no

If the insurer does not reply within 10 days would you like us to proceed with booking the assessment and agree to protect our account? yes no

If OCF 18 denied, proceed with assessment and protect our account? yes no

Report due by:

Notes:

***signed OCF-18 by the insured must be included in order for us to submit a treatment and assessment plan under the new regulations**