

**RTW INTEGRATED HEALTH
MANAGEMENT INC.**
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**Disability Management &
Rehabilitation Counselling
Services**

**Dr. J. Douglas Salmon, Jr. &
Associates**
www.dr.salmonassociates.com

REFERRAL

CLIENT INFORMATION

Date of Referral: _____

REFERRAL SOURCE _____

CONTACT _____ Phone _____

MVA Other Gender: () M () F

Client Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

Diagnosis: _____ Catastrophic Yes No

Date of Loss: _____ Date of Birth: _____

Ins. Co: _____ Claim # _____

Adjuster: _____

Phone: _____ Fax: _____

Client preferred Language: _____ Interpreter Required: Yes No

OCF 22 (specify) OCF 19

OCF 18 (specify)

ASSESSMENT/TREATMENT SERVICES

- Multidisciplinary Integrated Clinical Coordination
 - OT In-Home Safety Assessment
 - Form 1
 - OT Med-Rehab Assessment
 - Cognitive Rehabilitation (mild to moderate impairments)
- RN Assessment with Baseline ROMS
- CAT rebuttals (through Dr. Salmon Associates)
- Rehabilitation counselling
- FAE/FCE
- CASE MANAGEMENT:

VOCATIONAL SERVICES

- Vocational Counselling/Exploration
- Situational Assessment: 2 day ____ 3 day ____
- Other Vocational Services
- Post 104 Rebuttal: Disability Ax
- Work Hardening Program: _____ (# of weeks)

- FUTURE COST OF CARE/LCP
- Loss of Earning Capacity Asst (LEC)
- PVA/NPA already completed? yes ____ no ____
- Specialty Assessment: _____ (specify)
- Pain/Trauma Functional Recovery Program
- Other

OFFICE USE ONLY: Entered on Log

Assessing Clinician: _____

Phone: _____ Assessment Date: _____

Thank you for your referral

Email: melissa.lafferty@rrees.com