REFERRAL REQUEST

Email: [**referrals@ot-works.com**](mailto:referrals@ot-works.com)

Phone: **604.696.1066** ext 1000

Fax: **604.648.8078**

Referral Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Your Name\*** |  | | | | | |
| **Your Email\*** |  | | | **Your**  **Phone\*** |  | |
| Your Relationship to Client | * GP | * Lawyer | * Insurer | | * Client/family member | * Other: |
| **Occupational Therapy Services Requested\*** | * Assessment (home / work / ergonomic) * Rehabilitation: (choose one)   + Return to work   + Return to function * Workplace accommodation | | | * Disability/Case management * FCE (Functional Capacity Evaluation) * CFC (Cost of Future Care assessment) * PGAP (Progressive Goal Attainment Program) * Other (specify): | | |
| Reason for Referral  (why is OT needed?) |  | | | | | |
| Are injuries from a Motor  Vehicle Accident? | * YES | * No |  | |  |  |
| Contact Me for more  information | * YES | * No |  | |  |  |

Client Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name\*** |  | | |
| **Client Email\*** |  | **Client Phone\*** |  |
| **Client Address\***  (or City if known) |  | | |
| **Diagnosis/Injury\*** |  | | |
| PHN  (Provincial Health Number) |  | | |
| Date of Loss |  | Date of Birth |  |

Billing Information

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Same as Requestor? \*** | YES / NO  (if No, please complete the fields below) | | | | | | |
| **Billing Contact Name** |  | | | | | | |
| **Billing Contact Email** |  | | | **Billing Contact Phone** | |  | |
| **Mailing Address\*** |  | | | | | | |
| Billing Contact FAX |  | | | | | | |
| Relationship to Client**\*** | * GP | * Lawyer | * Insurer | | * Client/family member | | * Other: |

ICBC Claim

ICBC requires a GP note recommending Occupational Therapy after an MVA. Please include the GP referral for timely service. If you have a lawyer, please provide contact information.

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Claim / File #\*** |  | | |
| Lawyer Name |  | Lawyer Phone or Email |  |

\* = Required information. Please complete the fields indicate with a \* to the best extent possible Complete and return by e-mail: [**referrals@ot-works.com**](mailto:referrals@ot-works.com)or by **Fax 604.648.8078**

**Questions?** Please call 604.696.1066 ext 1000 © 2025 OT Works! Ltd.