



225 DUNCAN MILL RD., SUITE 310, TORONTO, ON M3B 3K9
 TEL: 416-445-4455 • FAX: 416-445-1090 • 1-866-245-6666
Please complete this Referral Form: print and fax to 416-445-1090

ADJUSTER:	DATE:
COMPANY:	PHONE #:
ADDRESS:	FAX#:

CLAIM / POLICY:	DATE OF LOSS:
CLAIMANT:	DATE OF BIRTH:
ADDRESS:	PHONE #:

FAMILY PHYSICIAN:	LEGAL:
ADDRESS:	COMPANY:
	ADDRESS:
PHONE #:	PHONE #:
FAX #:	FAX #:

IME/FAE/REPORT SERVICES

<input type="checkbox"/> CARDIOLOGY	<input type="checkbox"/> ORTHOPAEDIC	<input type="checkbox"/> RHEUMATOLOGY
<input type="checkbox"/> DENTAL	<input type="checkbox"/> OTOLARYNGOLOGY	<input type="checkbox"/> FAE
<input type="checkbox"/> NEUROLOGY	<input type="checkbox"/> PHYSIATRY	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> NEUROPSYCHOLOGY	<input type="checkbox"/> PSYCHIATRY	<input type="checkbox"/> OTHER _____
<input type="checkbox"/> OPHTHALMOLOGY	<input type="checkbox"/> PSYCHOLOGY	

SPECIAL CONSIDERATIONS:	<input type="checkbox"/> Copy of report to claimant
<input type="checkbox"/> Copy of report to referral source	<input type="checkbox"/> Send letter of confirmation to family physician
<input type="checkbox"/> Copy of report to family physician	<input type="checkbox"/> Arrange transportation
<input type="checkbox"/> Copy of report to legal	<input type="checkbox"/> Arrange interpreter: _____

Office Use Only:

CONFIRMATION DATE:	<input type="checkbox"/> Faxed to legal
<input type="checkbox"/> Faxed confirmation to referral source	<input type="checkbox"/> Faxed to specialists
	<input type="checkbox"/> Couriered to claimant