Occupational Health Clinics for Ontario Workers
Centre de santé des travailleurs et travailleuses de l'Ontario

REFERRAL FORM

Referral Date:_____

In order for OHCOW Inc. to be efficient in assisting you and your client, the following client information **must be provided** as well as their ***full*** WSIB and/or medical file. If possible, a photo of the worksite/tools used/work station would be helpful. Please ensure all pages are complete. If not, the referral will be returned to you. As well, please ensure that your client has completed the consent to discuss case and release the report.

Name:			☐ M ☐ F
Date of Birth (m/d/y)		Date of Death (m/d/y/) (if applicable):	
Address			*Email:*
City		*Postal Code:*	Telephone:
Name of Executor(ix) (copy of will needed)			
Referred by:		Agency:	
Telephone:	Fax:		*Email:*

What is the diagnosis confirmed by a licensed physician or nurse practioner?		
	Yes	No
Has the client filed a WSIB claim?		
Was the claim accepted?		
Did the client receive any money from WSIB for this in the past?		
Is the client currently receiving any money from WSIB for this problem?		
Do you or your client have an up-to-date WSIB file?		
Was the claim denied on a technicality?		
Is your client currently working?		

What is the medical diagnosis? _____

What is it that you want OHCOW to do for your client?

_____
_____
_____
_____

Accident Employer: _____Position: _____

Please provide a brief history of work accident or illness:

_____
_____
_____
_____
_____
_____

Prioritizing Referrals: Please be advised that all files are treated on a first-come-first serve basis. However, the advocate must provide compelling reasons in writing for advancing the status of any one of their referrals.

I request and authorize the Occupational Health Clinics for Ontario Workers Inc. (OHCOW) to discuss my case and release the clinical report to:

Referring agency/name:	
Address	
City	*Postal Code:*
Client signature:	Date signed:
Witness:	Print name: