

**ADVOCATE REFERRAL FORM**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Services not offered**:

* Acute treatment or ongoing medical care
* Non-work-related health problems
* Fitness for work or modified work determinations
* Musculoskeletal problems from more than 10 years ago;
* Pre-1990, FEL or NEL level of disability appeals or re-assessments
* WSIB case management
* Disability Claims (i.e. CPP, STD, LTD, EI, ODSP)

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/workstation would be helpful.

**CLIENT INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Legal Name: Last First Middle | | | Preferred Name: |
| Complete Address (Street Name and Number, City/Town, Province, Postal Code): | | | |
| Home Tel: | Alternate Tel: | | Email: |
| Date of Birth: mm/dd/yyyy | | Date of Death: mm/dd/yyyy | |
| Name of Executor(ix): To be filled in only if worker is deceased (copy of first & last page of Will needed): | | | |
| Referred by: | | Agency: | |
| Telephone: | Fax: | | Email: |

**MEDICAL DIAGNOSIS & WSIB CLAIM**

|  |  |  |  |
| --- | --- | --- | --- |
| What is the confirmed diagnosis relating to this referral? | | | |
| WSIB Claim Number | Nature of injury/illness | Date of Claim | Claim Status |
|  |  |  | 🞎 Accepted  🞎 Denied  🞎 Unknown |

|  |  |  |
| --- | --- | --- |
| Is the worker currently receiving money from the WSIB for this issue? | 🞎 Yes | 🞎 No |
| Was the claim denied on a technicality? | 🞎 Yes | 🞎 No |
| Is the worker currently working? | 🞎 Yes | 🞎 No |

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accident Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide a brief history of the work accident or illness:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER/PREVIOUS WSIB CLAIMS**

|  |  |  |
| --- | --- | --- |
| Claim Number | Nature of injury/illness | Claim Status |
|  |  |  |
|  |  |  |
|  |  |  |

**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. 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.

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

|  |  |
| --- | --- |
| Referrer Name/Agency: | |
| Complete Address: | |
| Client Signature: | Date Signed: |
| Witness Signature: | Print Witness Name: |