

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
			<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> 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: