

## HEALTH PROFESSIONAL REFERRAL FORM

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

**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)

**PATIENT 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: <span style="color: gray;">mm/dd/yyyy</span>	Health Card Number:		Patient Aware of Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Referring Health Professional Name:				
Complete Address:				
Telephone:	Fax:		Email:	

**Issue/Reason for Referral:**

**\*\*\*Please include any relevant consults/test results with this referral\*\*\***

Enquiries are welcome regarding determination of work-relatedness and prevention strategies.

OHCOW staff include: occupational hygienists; ergonomists; occupational health nurses; occupational health physicians; and administrative professionals.

OHCOW is a not-for-profit clinic. There is no charge for our services.