



OBJECTIVE ASSESSMENTS, CONSULTATION AND EFFECTIVE TREATMENT
Program of Grand River Hospital

Referral Form Regional Evaluation Centre (REC)

Please note, items marked with an asterisk (*) are considered mandatory items

Client Information

*Name	_____	*Home Ph#	_____
Address	_____		
	City	Postal Code	_____
*DOB d/m/y	_____	Sex	Male { } Female { }
Employer	_____		
*WSIB Claim#	_____	SIN#	_____
*Date of Injury	day	mth	yr
Re - occurrence	Yes	No	Date of Referral
			day mth yr

Medical Information

Diagnosis:	_____
History of Previous Injuries:	_____
Other Medical Concerns:	_____

Investigations / Treatment

	AREA	DATE	RESULTS
XRAY	_____	_____	_____
BONESCAN	_____	_____	_____
CT SCAN	_____	_____	_____
EMG	_____	_____	_____
MRI	_____	_____	_____
Other	_____	_____	_____
Has the patient seen another health care professional for this problem? If yes, provide relevant details.			

Physiotherapist	_____	Psychologist	_____
Social Worker	_____	Massage Therapist	_____
		Chiropractor	_____
		Medical Specialist	_____
		Occupational Therapist	_____
		(Name)	_____
Referral Questions	_____		

Nurse Case Manager (NCM) / Practitioner Information

NCM / Treating Practitioner's Signature	_____	Phone	_____
		Fax#	_____
NCM / Treating Practitioner's Name (please print)	_____	Date	_____