



# Referral Form

"An ExamWorks Company"

<b><i>Patient Information:</i></b>
Patient Name: (first last)
Reference Number:
Date of Disability/Illness:
Date of Birth:
Address: (Street, City, Postal code)
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Legal Rep Firm name:
Legal Rep: (first last)
Legal Phone and Fax:

<b><i>Referral Information:</i></b>
Name:
Company:
Telephone:
Fax/email:
Company Address:

### *Service requested:*

Defence Medical     Plaintiff Medical     File Review     Other, please specify: \_\_\_\_\_

Specialties Requested: (check all that apply)	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Orthopaedic
	<input type="checkbox"/> Dental	<input type="checkbox"/> Physiatry
	<input type="checkbox"/> FAE	<input type="checkbox"/> Physician (GP)
	<input type="checkbox"/> Job Site Analysis	<input type="checkbox"/> Physiotherapy
	<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Psychology
	<input type="checkbox"/> Neurology	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> OT in home	<input type="checkbox"/> Other: _____
	Preferred Time Frame:	
Date Report Required:		
Scheduling requests		
Injuries/Illness:		

**Interpreter Required:**  NO     YES, Language: \_\_\_\_\_    **Transportation:**  NO     YES

How would you like SOMA to confirm this request with you?     Telephone     Fax     Email

Should you require any further assistance or would like to speak with someone directly, please phone 905-881-8855.

***Thank you for your referral***

Please email this form to [referrals@somamedical.com](mailto:referrals@somamedical.com) or fax to **905-881-7887**