Auto Referral Form

Patient Information:	***Referral Information:***
Patient Name: (first last)	Adjuster Name:
Claim Number:	Company:
Date of Loss:	Telephone:
Date of Birth:	Fax/email:
Address: (Street, City, Postal code)	Company Address:
Gender: ☐ Male ☐ Female	Primary Referral Co:
	Primary Claim #:
Legal Rep Firm name:	Assistant Name:
Legal Rep: (first last)	Assistant Phone:
Legal Phone and Fax:	Assistant fax/email:

Service requested:

☐ In Person ☐ MIG ☐ CAT ☐ Paper Review

Specialties Requested:	☐ Chiropractic ☐ Dental ☐ FAE ☐ Job Site Analysis ☐ Massage Therapy ☐ Neurology ☐ OT in home	☐ Orthopaedic ☐ Physiatry ☐ Physician (GP) ☐ Physiotherapy ☐ Psychology ☐ Other: ____________________ ☐ Other: ____________________
Disputed Benefits:	☐ Income Replacement Benefits ☐ Non-Earner Benefits ☐ Caregiver Benefits ☐ Medical and Rehabilitation Benefits ☐ Housekeeping and Home Maintenance	☐ Attendant Care Benefits ☐ POST 104 Weeks Disability ☐ CAT Determination ☐ Other Benefits
Provider on OCF 18:		Date of OCF 18:
Total Amount:		
Description of goods and services:		
Preferred Time Frame &/or 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 or fax to **905-881-7887**