



St. Mary's of the Lake Hospital site  
**REHABILITATION MANAGEMENT SERVICES**

Mailing address: P.O. Box 3600 - Kingston, ON - K7L 5A2

Site location: 28 Barrie Street, Kingston

Tel: 613-548-2327

Fax: 613-548-6110

# REQUEST FOR SERVICE

Date of request (Y/M/D)

## CLIENT INFORMATION

|                       |                |                       |                             |
|-----------------------|----------------|-----------------------|-----------------------------|
| Client name – Surname | Given name     | Date of birth (Y/M/D) | Telephone                   |
| Home address – Street | City, Province | Postal Code           | Claim/Policy Number         |
|                       |                |                       | Date of Loss/Injury (Y/M/D) |

## SOURCE OF REFERRAL

|   |                |             |
|---|----------------|-------------|
| Primary Referral Source (print name of Agent) | Company Name   | Telephone   |
| Address – Street                              | City, Province | Postal Code |
|   |                | Facsimile   |

## EMPLOYMENT INFORMATION

|                              |                |
|------------------------------|----------------|
| Name of Employer             | Job Title      |
| Address of Employer – Street | City, Province |
|                              | Postal Code    |
| Contact Person               | Telephone      |
|                              | Facsimile      |

## MEDICAL INFORMATION

|   |                |
|---|----------------|
| Names of Care Providers (i.e. Family Physician) | Telephone      |
| Address – Street                                | City, Province |
|   | Postal Code    |
| Nature of Disability                            |                |

## REFERRAL OBJECTIVE

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|  |
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## SERVICES REQUESTED

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Disability Case Manager | <input type="checkbox"/> Future Care Costs/Life Care Planning    | <input type="checkbox"/> Transferable Skills Analysis  |
| <input type="checkbox"/> Vocational Assessment   | <input type="checkbox"/> Labour Market Survey                    | <input type="checkbox"/> Physical Demands Analysis     |
| <input type="checkbox"/> Work Skills Assessment  | <input type="checkbox"/> Functional Capacity Evaluation          | <input type="checkbox"/> Ergonomic Assessment          |
| <input type="checkbox"/> Work Site Evaluation    | <input type="checkbox"/> Occupational Therapy In-Home Assessment | <input type="checkbox"/> Occupational Therapy Services |

## BILLING SOURCE

|   |                |
|---|----------------|
| Name  | Organization   |
| Address – Street  | City, Province |
|   | Postal Code    |
|   | Telephone      |
| Claim Number  | Policy #       |
| Please attach any additional information                                      |                |
| Documents attached – <input type="checkbox"/> Yes <input type="checkbox"/> No |                |