OCF-18 Referral Form:

First name: Click or tap here to enter text.

Last name: Click or tap here to enter text.

Gender: Choose an item.

Date of birth (YYYY/MM/DD): Click or tap to enter a date.

Address 1: Click or tap here to enter text.

City: Click or tap here to enter text.

Province: Click or tap here to enter text.

Postal code: Click or tap here to enter text.

Phone: Click or tap here to enter text.

Email address: Click or tap here to enter text.

Claim number: Click or tap here to enter text.

Policy number: Click or tap here to enter text.

Date of accident (YYYY/MM/DD): Click or tap to enter a date.

**Auto insurer information**

Insurance company name: Click or tap here to enter text.

City/Town of branch office: Click or tap here to enter text.

Adjuster last name: Click or tap here to enter text.

Adjuster first name: Click or tap here to enter text.

Adjuster phone number: Click or tap here to enter text.

Is the policy holder the same as the applicant?

[ ]  Yes

[ ]  No

**Referral Information**

Case manager first name: Click or tap here to enter text.

Case manager last name: Click or tap here to enter text.

Case manager phone number: Click or tap here to enter text.

Case manager email address: Click or tap here to enter text.

Reason for client referral: Click or tap here to enter text.

Looking for:

 [ ]  Assessment

 [ ]  Treatment

**Other Insurer Information** – please provide details for other insurer coverage (up to 2 insurers), where applicable.

Other insurer name: Click or tap here to enter text.

Plan/policy number: Click or tap here to enter text.

Last name of plan member: Click or tap here to enter text.

First name of plan member: Click or tap here to enter text.

Other insurer’s identifier (if applicable): Click or tap here to enter text.

Is this impairment predominantly a minor injury as referred to in the Minor Injury Guideline applicable to the accident?

 [ ]  No

 [ ]  Yes

 [ ]  Not Applicable

**Injury and Sequelae Information** – Provide the associated ICD-10-CA code for complaints, injuries, and sequelae that are the direct result of the automobile accident.

1. Click or tap here to enter text.

2. Click or tap here to enter text.

3. Click or tap here to enter text.

Explain any psychological/mood challenges (e.g., depression, anxious, PTSD) that are the result of the automobile accident:

Click or tap here to enter text.

Explain any cognitive challenges (e.g., memory, concentration issues) that are the result of the automobile accident:

Click or tap here to enter text.

Explain any neurological challenges (e.g., headaches, migraines) that are the result of the automobile accident:

Click or tap here to enter text.

Describe how the patient’s impairment(s) from the injuries affect their ability to carry out:
 1. Tasks of employment: Click or tap here to enter text.

2. Activities of normal life: Click or tap here to enter text.

3. Tasks of school: Click or tap here to enter text.

If the patient is unable to carry out pre-accident employment activity, is the employer able to provide suitable modified employment to the applicant?

 [ ]  No or N/A, please explain: Click or tap here to enter text.

 [ ]  Yes

 [ ]  Unknown

 [ ]  Not Employed