



**ABI/TBI Cognitive-Communication Rehabilitation Referral Form**

**SERVICES REQUESTED:**

- Assessment
- Therapy
- Consultation
- Other:  
\_\_\_\_\_

**FOR MOTOR VEHICLE COLLISION REFERRALS:**

Date of loss: \_\_\_\_\_  
Injury designation:  
Catastrophic Non-catastrophic Other \_\_\_\_\_  
Claim number: \_\_\_\_\_  
Policy number: \_\_\_\_\_  
OCF-18 required? Yes No (Verbal consent? Yes No)

**REFERRAL DATE:** \_\_\_\_\_

**CLIENT:**

Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary address: \_\_\_\_\_

Email: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

Secondary contact (relation): \_\_\_\_\_

Diagnosis/es: \_\_\_\_\_

Cause of ABI/TBI: \_\_\_\_\_

Reason for referral/primary concern: \_\_\_\_\_

**PAYER/INSURANCE DETAILS:**

Type of insurance: Auto EHB WSIB Other \_\_\_\_\_

Contact/Adjuster Name: \_\_\_\_\_

Company Name: \_\_\_\_\_ Branch: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policy holder (if not client) First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Other insurance coverage potentially available: WSIB EHB Auto Other: \_\_\_\_\_

Other insurer name: \_\_\_\_\_ Plan or policy number: \_\_\_\_\_

**LAWYER (IF APPLICABLE):**

Name: \_\_\_\_\_ Law clerk: \_\_\_\_\_

Firm: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext \_\_\_\_\_ Fax: \_\_\_\_\_

Location/Address: \_\_\_\_\_

**REFERRER:**

Same as above

Name/title/role: \_\_\_\_\_

Organization/location: \_\_\_\_\_

Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Other: \_\_\_\_\_

Please indicate the following:

- Client/substitute decision-maker aware and consents to this referral.
- Sufficient medical documentation exists re: current concern, diagnosis of mTBI/TBI.  
[If available, please forward physician medical records; neuroimaging results; neurology, neuropsychology, psychology, or any relevant specialist consultation/assessment reports]  
\_\_\_\_\_
- Service considerations/modifications required (language, mobility, consent capacity, etc.):  
\_\_\_\_\_
- Concurrent/previous rehabilitation services: \_\_\_\_\_  
\_\_\_\_\_
- Other: \_\_\_\_\_