Speech-Language Pathology
Motor Vehicle Collision 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): _____

Reason for referral/primary concerns: _____

Confirmed diagnosis/es: _____

Additional Information: _____

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:_____

Cell: 519-852-9771 Office: 519-873-1644 Fax: 1-800-599-8001 info@connectspeech.ca
230 Victoria Street Suite 210 London, ON N6A 2C2

LAWYER (IF APPLICABLE):

Name: _____ Law clerk:_____

Firm: _____Email:_____

Phone: _____ Ext_____ Fax: _____

REFERRER:

☐ Same as above

Name/title/role: _____

Organization/company: _____

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 ABI/ 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, travel, consent capacity, etc.):
  _____
- ☐ Current and/or previous rehabilitation services:
  _____
  _____
- ☐ Other: _____

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