ODYSSEY HEALTH SERVICES

Referral Form

DATE OF REFERRAL	Month:	Day:	Year:
WHICH SERVICE ARE YOU REQUESTING?	☐ Multidisciplinary Health Services (MHS)		
	☐ ACTive Recovery Solutions (ARS)		
	☐ Functional Restoration Services (FRS)		
	☐ Psychological Assessment (Potential Treatment)		
	☐ Psychological IME (No Treatment)		
	☐ Not sure. Please contact me		
NAME OF CONTACT			
ORGANIZATION			
PHONE NUMBER		FAX NUMBER	
EMAIL ADDRESS			
PATIENT SURNAME			
PATIENT FIRST NAME			
ADDRESS			
PRIMARY PHONE #			
GENDER			
DATE OF BIRTH	Month:	Day:	Year:
DATE LAST WORKED	Month:	Day:	Year:
CHANGE OF DEFINITION DATE	Month:	Day:	Year:
CURRENT DEFINITION OF DISABILITY		GAINFUL LEVEL	
POLICY #		EMPLOYEE #	
PORTFOLIO #		CLAIM #	
PRIMARY PHYSICIAN			
PHONE #		FAX #	
NAME OF EMPLOYER			
POSITION			
CONTACT PERSON			
PHONE#		FAX #	
IS THERE A JOB TO RETURN TO?	☐YES		☐NO
ARE WE RETURNING THIS INDIVIDUAL TO THEIR OWN OCCUPATION?	☐YES		☐NO
LITIGATION INVOLVED	☐YES		☐NO
OTHER COMMENTS			

PLEASE ATTACH **ALL** MEDICAL DOCUMENTATION YOU HAVE FOR THE FILE

Please Return to Lynn Luchka
EMAIL: intake@ohs-jma.com
FAX: 905-390-3017