ODYSSEY HEALTH SERVICES

OHS-JMA Referral Form

Version March 2024

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 LEGAL NAME (First, Initial, Last)			
PATIENT PREFERRED NAME (First, Initial, Last)			
PATIENT PRONOUNS	☐ She/Her ☐ He/Him ☐ They/The ☐ Prefers not to say ☐ Let me enter		
FULL ADDRESS (Street, Unit, City, Province, Postal Code)			
HOME PHONE #		**MOBILE PHONE #**	
EMAIL ADDRESS			
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 ($)**	
% OF PRE-DISABILITY SALARY			
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 ☐ UNSURE		
ARE WE RETURNING THIS INDIVIDUAL TO THEIR OWN OCCUPATION?	☐ YES ☐ NO ☐ UNSURE		
LITIGATION CURRENTLY INVOLVED	☐ YES ☐ NO ☐ UNSURE		
OTHER COMMENTS			

PLEASE ATTACH ALL MEDICAL DOCUMENTATION YOU HAVE FOR THE FILE

RETURN THIS FORM TO Intake@ohs-jma.com OR FAX 905-390-3017