

# Rehabilitation Support Worker Referral Form

## Elements Support Services Referral Form

364 Wilson Ave.  
Burlington, Ontario  
L7L 2M9

---

Referred By: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
email: \_\_\_\_\_  
Address: \_\_\_\_\_

Company: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Date of Referral: \_\_\_\_\_  
File #: \_\_\_\_\_

### CLIENT INFORMATION

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Date of Injury: \_\_\_\_\_  
DOB: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Treatment Plan: Y \_\_\_\_\_ N \_\_\_\_\_

### Anticipated Goals of Rehabilitation Worker:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_

### FUNDER INFORMATION

Company: \_\_\_\_\_ Contact Person: \_\_\_\_\_ File #: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ email: \_\_\_\_\_  
Address: \_\_\_\_\_

### REHABILITATION TEAM MEMBERS:

Name: \_\_\_\_\_ Role: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Role: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Role: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

Name: \_\_\_\_\_ Role: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_

---

Please fax the referral form along with reports and other relevant information to the attention of Paul Mc Cormack at Fax # 905-637-5412. If you have any questions or prefer to conduct the referral by phone, please call Paul at 289-259-1354.