ERGO-*Wise*
2571 Carling Avenue, Suite 205
Ottawa, Ontario
K2B 7H7

Tel: 613-726-6329
Fax: 613-228-8642
info@ergo-wise.com
www.ergo-wise.com

REFERRAL FORM

Thank you for your referral! Please print this form, complete it and fax back to **613-228-8642.**

Client: _____ Date: _____

Control number: _____ Policy number: _____

Off work since: _____

Referral Purpose: Please tick (✓)

____ Cognitive work hardening

____ OT (activation/goal setting)

____ Pain management (PGAP)

____ Worksite assessment

____ Job accommodation assessment

____ Ergonomic assessment

____ Personal skill development:

☐ assertiveness ☐ organizational skills / time mgt ☐ conflict mgt

____ Workshop / Lunch'n Learn:

☐ ergonomics ☐ job accommodation ☐ workplace mental health

____ Other _____

____ Other _____

Referral Source:

Referring agent: _____

Title: _____

Referral agency: _____

Telephone: _____

Email: _____

Fax: _____

Address: _____

Client Information:

Client: _____ D.O.B.: _____

Address: _____ Phone number: _____

Diagnosis: _____ Treating doctor: _____

Client employer: _____

Job title: _____

Education: _____

_____

Referral Objective(s):

_____

_____

_____

_____

_____

_____

_____

Background Information:

_____

_____

_____

_____

_____

Considerations:

_____

_____

_____