Occupational Concepts
get back to living
retrouver une vie active

# Pain and Disability Management Group

## Referral Form

THE ATLANTIC PAIN CLINIC INC.

Referring Agency: _____
Address: _____
_____
Phone: _____ Fax: _____
E-Mail: _____
Contact Person: _____

Employer: _____
Address: _____
_____
Phone: _____ Fax: _____
E-Mail: _____
Contact Person: _____

Client: _____ Claim/File Number: _____
Address: _____
Phone: _____ D.O.B. (mm/dd/yyyy): _____ Occupation: _____
Date of Injury/Illness (mm/dd/yyyy): _____ Diagnosis: _____
Family Physician: _____ Specialist: _____

**File Documentation Requirements** – *in chronological order:*

- An injury first report
- Ambulance and Emergency Room records, where applicable
- Hospital In – Patient record, where applicable
- All Family Physician / General Practitioner Form 8/10's or equivalent reports
- All relevant Radiology reports
- All relevant Laboratory reports
- All relevant Medical specialty consultation reports
- All relevant Surgical Reports and Operative reports, where applicable
- All claim related Psychological evaluations and reports
- All Paramedical evaluation and treatment reports
- All Job Site Analyses and Functional Capacities evaluations
- A complete pharmacy / medication list dating to the date of injury
- Any other collateral information the Case Manager and/or Family Physician may deem relevant

☐ Multidisciplinary Active Functional Rehabilitation Program (MAFRP)
  ☐ Job Site Analysis *(pre-admission requirement)*
☐ Assessment only with recommendation - Dr. Evans

**Additional Requests**

☐ Gradual Return to Work
☐ Transferable Skills Analysis
☐ 2-Day Functional Capacity Evaluation *(upon completion of program)*
☐ Ergonomic Assessment

Special Instructions: _____
_____
_____

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