



Referral form

1. Client Information

Full Name:	
Date of Birth:	
Contact Number:	
Email Address:	
Preferred Language:	
Cultural Background:	
Emergency Contact (Name & Phone):	

2. Injury Details

Date of Injury:	
Injury Diagnosis:	
Treating Physician:	
Current Work Status:	
Employer Name & Contact:	
Medical Clearance (Yes/No & Date):	

3. Functional Limitations

Mobility Restrictions:	
Pain Levels (Scale 1-10):	
Psychological Impact:	
Other Limitations:	
Assistive Devices Required:	

4. Work Capacity Assessment

Current Job Role:	
Work Duties Impacted:	
Modified Duties Available:	
Employer Support Level:	
Medical Restrictions/Limitations:	
Expected Return-to-Work Date:	

5. Psychosocial & Environmental Factors

Family Support Available:	
Community Support Services Used:	
Cultural Considerations in Recovery:	

Mental Health Factors Affecting Recovery:	
Other Relevant Factors:	

6. Goals & Expectations

Worker's Recovery Goals:	
Barriers to Returning to Work:	
Support Needed for Successful Rehabilitation:	

7. Return-to-Work Readiness

Physical Readiness for Work:	
Psychological Readiness for Work:	
Required Workplace Adjustments:	
Expected Level of Productivity at Work:	

8. Consultant's Notes & Signature

Additional Comments:

Consultant Name: _____

Signature: _____ Date: _____