



INTAKE FORM

REFERRAL SOURCE

Agency/Organization

Lawyer

Insurance Company

Employer

Individual

Other: _____

Contact Person: _____ Title: _____

Contact Number: _____ Fax: _____

Address: _____

Email: _____

Client Information:

File Number: _____ Date of Loss: _____ (mm/dd/year)

Name of Client: _____

Address: _____

Telephone: _____ Alternate: _____

Date of Birth: _____ (mm/dd/year)

Language Request:

English

French

No Preference

Best time to contact: _____ AM / PM

Reason for Referral:

- Automobile Accident
- Work Site Accident
- Bereavement/Trauma
- Counselling
- Other: _____

Type of Service Request:

- Grief Recovery Counselling
 - Group ,
 - individual,
 - management workshop
- Personal Adjustment Counselling
- Family Counselling
- Rehabilitation Consultant or Counselling

- Vocational Counselling/Assessments(case manager)

- Work site Assessments

- Ergonomic Assessments
- Life Care Planning
- Rehabilitation Services Consultant
- Catastrophic Case Management
- Attendant Care Assessment
- Housekeeping Assessments
- Massage Therapy
- Workshops/Wellness Seminars

Notes: _____

OFFICE USE ONLY

Referral Date: _____ (mm/dd/year)

Client Contacted: (contact within 24hrs of referral)

YES: _____ (date/time)

Written Confirmation

Phone Contact Confirmation

Completed By: _____

This referral form can be sent by:

FAX : 705 .693.4808

BY EMAIL: latituderehab@bellnet.ca

Contact our intake office:

705.693. WELL (9355)

866.690.2919