omegamedical ASSOCIATES

OMEGA MEDICAL REFERRAL FORM

CLIENT

Last Name		First Name	
Address			
Phone No.		Cell	
Birthdate		Gender	
Email			
Date of Loss			
Language			
Guardian/Parent if under Age 18	Contact information:		
Substitute Decision Maker	Contact Information:		
Special Needs	☐ Hearing impaired ☐ Wheelchair ☐ Scooter ☐ Literacy	☐ Visually impaired ☐ RSW/PSW - Attending ☐ Support Animal - Attending	

LEGAL

Firm			
Lawyer’s Name			
Email			
Clerk/Asst Name			
Email			
Firm Address			
Phone No.		Fax No.	
File No.			
LAT/Court Ref No.			

INSURER

Company			
Adjuster Name			
Email			
Policy No:			
Claim No.			
Address			
Phone No.		Fax No.	
If Independent Adjusting Company	Principle Insurer Name Claim/Ref Number		

Services Required *(circle and check)*

ASSESSMENT SERVICES

☐ **Medical-Legal**	☐ **OCF-19 CAT**	☐ **CAT REBUTTAL**

☐ Physiatry	☐ Neurophysiatry
☐ Orthopaedics	☐ Neurology
☐ ENT	☐ Internal Medicine
☐ Urology	☐ General Surgery
☐ Psychology	☐ Neuropsychology
☐ Psychiatry	☐ Neuropsychiatry
☐ Occupational Therapy – Situational	☐ FAE
☐ GAIT Assessment – Physiotherapy	☐ Upper Extremity Evaluation - OT

INVESTIGATIONS- OCF-18- Medical/Rehabilitation

☐ EMG
☐ SPECT/MRI- Brain
☐ Ultrasound
☐ Physiotherapy Services
☐ Psychology Services

TREATMENT SERVICES- OCF-18- Medical/Rehabilitation

☐ Physiatry Clinic -Treatment Planning
☐ Neurology Clinic – PCS/ TBI/ HEADACHES
☐ OT Treatment ☐ Attendant Care Needs with Form 1 ☐ Future Care Costs
☐ Physiotherapy Services
☐ Psychology Services

Special instructions/notes: