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**		

omegamedical ASSOCIATES

CASE MANAGER / OCCUPATIONAL THERAPIST

Company			
CM/OT Name			
Email			
Address			
Phone No.		**Fax No.**	
File No.			

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 -- Other
☐ Ultrasound

TREATMENT SERVICES- OCF-18- Medical/Rehabilitation

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

Special instructions/notes: