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## WORKERS' REHABILITATION CENTRE REFERRAL FOR ADMISSION

### CLAIMANT INFORMATION

NAME: ADDRESS: TELEPHONE #: DATE OF BIRTH: S.I.N: MEDICARE #:	CLAIM #:  DATE OF ACCIDENT: EMPLOYER: OCCUPATION: IS CLIENT JOB ATT.?:
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### REFERRAL SOURCE INFO

NAME:	TEL.#: If not a WorkSafeNB Case Mgr	CAUTION FLAG <input type="checkbox"/>
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### ADMISSION INFORMATION

REQUESTED-ADMISSION DATE: _____	RE-ADMISSION: _____
URGENT ADMISSION: _____	HOTEL REQUIRED: _____
REASON FOR URGENCY: _____	CLIENT'S LANGUAGE: _____
DIAGNOSIS:	
REASON FOR REFERRAL:	
SPECIFIC GOAL / QUESTION:	

COMPLETED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

CLAIMANT NAME: \_\_\_\_\_ CLAIM NUMBER: \_\_\_\_\_

Please mark the appropriate service(s) with an 'X'

**WORK RECOVERY**

**TEAM**

- Level as per Team's Discretion
- Multidisciplinary Consultation
- Stalled Return to Work
- Motivational Enhancement Therapy (MET) followed by Work Recovery Program
- Motivational Score: \_\_\_\_\_
- Medium / Heavy
- Sedentary / Light
- Mild Traumatic Brain Injury (MTBI)
- Cumulative Trauma Disorder (CTD)
- Complex Regional Pain Syndrome (CRPS)/ Reflex Sympathetic Disorder (RSD)
- Team Re-assessment
- Opioid Reduction Screening
- Opioid Reduction **with** RTW Goal
- Opioid Reduction **without** RTW Goal

**EDUCATION**

- Understanding Safe Work Practices
- Transfer Class
- Understanding Pain
- Other: \_\_\_\_\_
- Benefits of Exercise

**SINGLE DISCIPLINE SERVICE**

- Work Conditioning
- Medical Exam and transfer into Work Recovery if appropriate
- Physiotherapy
- Psychological Counselling
- Occupational Therapy
- Gradual Return to Work
- Independent Medical Examination
- Biofeedback
- Social Work Counselling
- Nutrition Counselling
- Medical Examination
- PPI
- T.E.N.S
- Chiropractic Consultation
- Other: \_\_\_\_\_

**VOCATIONAL EVALUATION**

- Neuropsychological
- Ergonomic Evaluation
- Job Site Analysis: Enter Job Title, Contact Person & Phone #
- Psychological Assessment: Enter Type of Assessment
- Job Specific Evaluation: Enter Job Title, Contact Person & Phone #
- Physical Status
- Job Spec/General: \_\_\_\_\_
- General Capacity Evaluation
- Risk Factor Analysis
- Job Site Evaluation (with client): Enter Job Title, Contact Person & Phone #

**ASSISTIVE DEVICES**

- Amputee Rehab
- Off-Site Evaluation Specify
- Hand Assessment & Therapy
- Assistive Devices: \_\_\_\_\_
- Mobility Assessments
- Assessment
- Occupational Therapy

UPI: _____	Entered: _____	Projected Admission Date: _____
Episode: _____	Scheduled: _____	