

WORKSAFE NB'S REHABILITATION CENTRE REFERRAL FOR SERVICE / SUPPLIES REQUEST

CLAIMANT INFORMATION

NAME: _____	CLAIM #: _____
ADDRESS: _____	
TELEPHONE #: _____	DATE OF ACCIDENT: _____
DATE OF BIRTH: _____	EMPLOYER: _____
MEDICARE #: _____	OCCUPATION: _____

REFERRAL SOURCE INFO

NAME: _____	Tel.#: _____
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REFERRAL FOR SERVICE: <input type="checkbox"/>	SUPPLIES REQUEST: <input type="checkbox"/>	Only complete Supplies Required / Authorized
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REASON FOR REFERRAL / GOAL:	
SUPPLIES REQUIRED / AUTHORIZED:	

SERVICE INFORMATION

URGENT ADMISSION: <input type="radio"/> Yes <input type="radio"/> No	RE-ADMISSION: <input type="radio"/> Yes <input type="radio"/> No
REQUESTED ADMISSION DATE (YYYY-MM-DD): _____	HOTEL REQUIRED: <input type="radio"/> Yes <input type="radio"/> No
CONTACT CASE MANAGER BEFORE BOOKING: <input type="radio"/> Yes <input type="radio"/> No	IS CLIENT JOB ATT? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
CLIENT'S LANGUAGE: _____	CAUTION FLAG: <input type="checkbox"/>

DIAGNOSIS:	
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COMPLETED BY: _____ DATE: _____

