Inquiry and Referral Form

Fax referral form to: 905-777-0224 or
send by Secure portal at www.acemedicalexams.ca

Company Information			**Initial Inquiry Date:**		
Company Name:			Toll Free:		Fax
			Phone:		Ext.
Contact Name:			Address:		
Email:					
Referral Source type:	☐ Reception Services	☐ Legal	☐ Insurance	☐ Employer	☐ Other:

Evaluee Information		
Name:	Claim/Employee #:	
Gender:	Phone:	Ext:
Date of Birth:	Address	
Date of Loss (if applicable):		
Clinical Coordination:		Completed by:
Interpreter Required: if yes, Language **{enter language}**	Transportation Required: Yes☐ or No☐	

Legal Representative	
Name:	Phone:
Company Name:	Fax:

Service Request	☐ In Person	☐ In-Home	☐ File Review	☐Diagnostics
☐ Case Management	☐ Massage Therapy	☐ Physiotherapy		☐ Bone Scan
☐ Chiropractic	☐ Neurology	☐ Psychology		☐ CT scan
☐ Dental	☐ Neuropsychology	☐ Psychiatry		☐ MRI
☐ FAE – Kin	☐ Occupational Therapist	☐ Return-to-Work Program		☐ Ultrasound
☐ FAE – RHP	☐ Occ. Health Physician	☐ Rheumatology		☐ Other:
☐ General Practitioner	☐ Ophthalmology	☐ Social Environmental Screening		
☐ Internal Medicine	☐ Orthopaedic	☐ Speech Language pathology		
☐ Job Site Analysis	☐ PDA	☐ Transferrable Skills Analysis		
☐ Labour Market Survey	☐ Physiatry	☐ Vocational		
☐ Other:				

Reporting Requirements		
Send report to:		
Send report by:	☐ SecureDocs	☐ Fax:
Report to contain medical information? ☐ Yes or ☐ No		
Additional Information:		

Invoicing Requirements		
Send invoice to:		
Send invoice by:	☐ SecureDocs	☐ Fax:
Additional Information:		

Office use only:	Referral Received Date:	Appt confirmed:	Letter to EVee req'd ☐Yes ☐ No	Reminder Call req'd ☐Yes ☐ No