LAKERIDGE HEALTH Wellness & Assessment CENTRE

Knowledge – Integrity – Professionalism

223 Brock St. N.
Whitby, ON L1N 4H6
Tel: 905-666-8033
Fax: 905-666-0113
Email: kmichel@powergate.ca

Please fax through form and we will contact you within 24 hours for scheduling

CLAIMANT/ EMPLOYEE

Claim No.	Surname			Given Name & Initial
Telephone - -	Date of Birth (YYYYMMDD)	Age	Gender ☐ M ☐ F	Date of Accident (YYMMDD)
Address	City			Postal Code
Special Needs ☐ Mobility ☐	Interpreter (PLEASE SPECIFY BELOW)		Other (please specify) ☐	
Representative (if applicable)	Telephone		Fax	
Address	City		Postal Code	

INSURER/ EMPLOYER

Insurance Company/ Employer	Referrer Last Name		Referrer First Name
Address	City		Postal Code
Telephone	Fax		Email

PRIMARY CARE PROVIDER

Last Name	First Name		Health Profession
Address	City	Postal Code	Telephone

TYPE OF REFERRAL

❑ Please perform an Independent Evaluation addressing the following:

- ❑ Ability to return to work
- ❑ Ability to resume activities of normal living/caregiving
- ❑ Diagnosis
- ❑ Causality
- ❑ Prognosis
- ❑ Work Restrictions
- ❑ Treatment Review and Recommendations/ Further Recommendations
- ❑ Functional Abilities Evaluation – Medical Clearance Form will follow
- ❑ Work-site Assessment/ Ergonomic Evaluation
- ❑ Home-Site Assessment
- ❑ Residual Earnings Capacity

Assessor Specialty Preferred:_____

Specific Questions to be Addressed (please feel to attach a second page with questions):

Referred by: _____ Date_____

☐ Insurance Adjuster ☐ Representative ☐ Physician ☐ Employer ☐ Other

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Consent to Assessment/Treatment; Disclosure of Employment or Occupational Health Information; Disclosure of Clinical Record; and to the Collection, Use and Transmittal of Personal Information

I, _____ understand that I am being asked to participate in services provided by the **Wellness & Assessment Centre** at the request of my employer,

_____
(Name of Company)

The purpose of my involvement with the **Wellness & Assessment Centre** has been explained to me.

(B) I authorize the release of my employment or occupational health record to the **Wellness & Assessment Centre** for their use in the delivery of services. I further allow contact with my supervisor _____ if deemed necessary to provide such service.
(Supervisor's Name)
Supervisor's Tel:_____

(C) I authorize the release of my clinical record as collected by _____
(Name of Healthcare or Service Provider)
to the **Wellness & Assessment Centre** for use in their delivery of services. I understand that the information will be reviewed and may be reported to my employer during the provision or at the completion of the services provided.

Healthcare Contact Information:

Address:_____ Telephone:_____
_____ Fax:_____
_____

(D) I understand the **Wellness & Assessment Centre** collects personal health information about me for the purposes of assessment, treatment, payment, quality improvement, program evaluation, administrative functions, statistics, and legal and regulatory accountability requirements. I understand that my personal health information will not be used or disclosed without my consent unless a particular use or disclosure is permitted or required by law without consent. I understand that upon conclusion of services provided, a report will be issued to my employer.

I understand that I can refuse to sign this consent form or, if I do sign, I can withdraw or amend this authorization in writing at any time, except where action has already been taken in reliance on the authorization.

I hereby consent to:

(A) participate in the program as described above;
(B) the release of my employee record;
(C) the release of my clinical record;
(D) the collection, use, and transmittal of my personal information as described above.

_____	_____	_____
My signature or substitute decision-maker	*Print name*	*Date (dd/mm/yy)*
_____	_____	_____
Witness signature	*Print name*	*Date (dd/mm/yy)*