



SERVICES LTD.

Functional
Assessments
Consultation
and Therapy

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Adult Medical Legal Referral Form

Client Name: _____

Address: _____

Phone Number: _____

Alternate: _____

Date of Birth: _____

Date of Loss: _____

Family Physician: _____

Injuries Sustained: _____

Reason for Referral:

- | | |
|---|---|
| <input type="checkbox"/> Functional Capacity Evaluation | <input type="checkbox"/> Home Making Assessment |
| <input type="checkbox"/> Costs for Future Care | <input type="checkbox"/> Wrongful Death |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Other (please specify) |

Lawyer: _____

Lawyer Contact Information: _____

Signature: _____

Date: _____