HVE Healthcare Assessments

260 Edgeley Boulevard, Unit 22, Vaughan, ON, L4K 3Y4
T: 905.264.2020 | F: 905.264.2388 | TF: 1.888.639.3739
general@hvehealth.com | www.hvehealth.com

IME REFERRAL FORM

DATE OF REFERRAL: _____

Referral Source: **Referral Source File #:**	**Claims Rep:**	**Claims Assistant:**
Address:	**Phone#:** _____ **Email:** _____	**Phone#:** _____ **Email:** _____
Employee Information: **Name:** _____ **( ) Male ( ) Female** **DATE OF BIRTH:** **Address:** _____ **City:** _____ **Province:** _____ **Postal Code:** _____ **Phone (home):** _____ **Phone (cell):** _____ **Phone (work):** _____ **Email:** _____	**DATE OF Loss/Injury/Illness:** _____ **Represented: ( ) Yes ( ) No** **Legal Firm:** _____ **Address:** _____ **City:** _____ **Province:** _____ **Postal Code:** _____ **Phone:** _____ **Contact Name:** _____ **Email:** _____	**Reported Injuries & Additional Details:** _____ _____ **Special Accommodations:** **(Communications, Assistive Technology, Equipment)** _____ **Interpreter Required:** **( ) Yes ( ) No** **Language:** _____ **Transportation Required:** **( ) Yes ( ) No**

Description of Injury or Illness to be Assessed:	**Type of Assessment(s) requested:** _____ _____ ( ) PR or ( ) Direct **( ) No**	**INSTRUCTIONS TO VENDOR/REFERRAL QUESTIONS:**
File Info to follow: **( ) Yes ( ) No**	**Letter to Employee Required** **( ) Yes ( ) No**	