PEARSON MEDICAL ASSESSMENT CENTRE INC.

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Brampton, ON. L6T 5K1

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Date of Referral ____________ DOL: ___________ Referral Source: _____________

Assessments:

- ☐ In-Home ADL
- ☐ Form 1 – Attendant Care Needs
- ☐ Functional abilities evaluation
- ☐ Worksite
- ☐ Psychological
- ☐ Psychiatric
- ☐ Driving Anxiety
- ☐ Rebuttal
- ☐ Physiatry
- ☐ Orthopaedic
- ☐ Neurological
- ☐ Chronic Pain
- ☐ Vocational Assessment
- ☐ Transferable Skills Analysis
- ☐ Labour Market Survey
- ☐ Impairment Assessment
- ☐ Post 104-Week IRB Assessment
- ☐ Medical Legal Assessments

Others(______________________)

REFERRAL PARTICULARS

Benefits Claimed (check applicable) ☐ Non-Earner ☐ Housekeeping ☐ Caregiving ☐ IRB ☐ Attendant Care	Translation Required ☐ Yes ☐ No If Yes, Specify Language: ____________
Transportation Required ☐ Yes ☐ No	Comments: ___________________________________

CLIENT INFORMATION

Name	Gender: ☐ Male ☐Female
Address	
Home/Cell Phone	Date of Birth (M/Y/D):

INSURANCE COMPANY

Company Name		Adjuster	
Address			
Telephone	Fax	Claim #	Policy#

TREATING FACILITY

Name	Telephone	Fax
Address		

LEGAL REPRESENTITIVE

Contact Person	Telephone	Fax
Address		