Odyssey Health

# ODYSSEY HEALTH REFERRAL FORM

Version August 2025

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|---|---|---|---|
| **DATE OF REFERRAL** | Month: | Day: | Year: |
| **WHICH SERVICE ARE YOU REQUESTING?** | ☐ Psychological Assessment (Potential Long-Term Treatment - Excursion or Expedition) | | |
| | ☐ Psychological IME (No Treatment) | | |
| | ☐ Express Program (Short Term) ☐ Screening ☐ No Screening | | |
| | ☐ Unsure. Please contact me. | | |
| **NAME OF CONTACT** | | | |
| **ORGANIZATION** | | | |
| **PHONE NUMBER** | | **FAX NUMBER** | |
| **EMAIL ADDRESS** | | | |
| **CLIENT LEGAL NAME** (First, Initial, Last) | | | |
| **CLIENT PREFERRED NAME** (First, Initial, Last) | | | |
| **CLIENT PRONOUNS** | ☐ She/Her | ☐ He/Him | ☐ They/Them |
| | ☐ Prefers not to say | ☐ Let me enter | |
| **FULL ADDRESS** (Street, Unit, City, Province, Postal Code) | | | |
| **HOME PHONE #** | | **MOBILE PHONE #** | |
| **EMAIL ADDRESS** | | | |
| **DATE OF BIRTH** | Month: | Day: | Year: |
| **DATE LAST WORKED** | Month: | Day: | Year: |
| **CHANGE OF DEFINITION DATE** | Month: | Day: | Year: |
| **CURRENT DEFINITION OF DISABILITY** | | **GAINFUL LEVEL ($)** | |
| **% OF PRE-DISABILITY SALARY** | | | |
| **POLICY #** | | **EMPLOYEE #** | |
| **PORTFOLIO #** | | **CLAIM #** | |
| **PRIMARY PHYSICIAN** | | | |
| **PHONE #** | | **FAX #** | |
| **NAME OF EMPLOYER** | | | |
| **POSITION** | | | |
| **CONTACT PERSON** | | | |
| **PHONE #** | | **FAX #** | |
| **IS THERE A JOB TO RETURN TO?** | ☐ YES | ☐ NO | ☐ UNSURE |
| **ARE WE RETURNING THIS INDIVIDUAL TO THEIR OWN OCCUPATION?** | ☐ YES | ☐ NO | ☐ UNSURE |
| **LITIGATION CURRENTLY INVOLVED** | ☐ YES | ☐ NO | ☐ UNSURE |
| **OTHER COMMENTS** | | | |

**ALL MEDICAL DOCUMENTATION FOR THIS FILE IS INCLUDED** ☐ YES

**PLEASE RETURN THIS FORM by EMAIL to Intake@odysseyhealth.ca or by FAX to 905-390-3017**

**or through our** SecureDocs Link