SERVICE REQUEST FORM

Functional Abilities In Home Assessment

Name of Applicant: ______________________________ **DOB** ____________

Claim #: ______________________ **Policy #:** ______________________

Policy Holder: ____

Address: ____

Postal Code: ______________ **Phone #: (H)** ____________ **(W)** __________

Other Contact Person: Name and Phone #: ______________________________

Date of Injury: ____

Diagnosis: ____

Other Health Issues: ____

Tests and/or Treatment: ____

Treating Physician: ____

Language spoken: ____________________ **Translator required: yes** ____ **no** ____

Referral Date: ____________________ **Evaluation Date:** ______________

Claims Adjuster: ____________________ **Phone #:** ______________

Company: ______________________ **Fax #:** ______________

Is this an Insurer's Examination: ☐ **Yes** ☐ **No**

Assessment Goals: ____

Please Check: ☐ **IRB** ☐ **Caregiver** ☐ **Attendant Care** ☐ **Home Maintenance**

Name of legal Rep.: ____

Phone # of legal Rep.: ____________________ **Fax #:** ______________

Do you have any medical documentation, insurance forms? ☐ **Yes** ☐ **No**

SEND YOUR REFERRALS

by email to: **referrals@sunshinerehab.com**
by fax to: **416.787.9913**
Contact us at: **416.787.6812** or **contact@sunshinerehab.com**