Harbourside Rehabilitation Inc

- Vocational Rehabilitation and Counselling
- Ergonomic Assessments
- Case Management
- Occupational Therapy Services

Confidential when complete.

<table>
<tr><td rowspan="4">CLIENT</td><td colspan="2">Name:</td><td>Claim No.:</td></tr>
<tr><td colspan="2">Address:</td><td>Home Telephone:</td></tr>
<tr><td>Work Telephone:</td><td>Date of Birth:</td><td>Date of Loss:</td></tr>
<tr><td colspan="3">Diagnosis:</td></tr>
</table>

<table>
<tr><td rowspan="3">REFERRAL SOURCE</td><td colspan="2">Name:</td><td colspan="2">Title:</td></tr>
<tr><td colspan="2">Company:</td><td colspan="2">Address:</td></tr>
<tr><td>Phone:</td><td colspan="2">Fax:</td><td>Email:</td></tr>
</table>

<table>
<tr><td rowspan="4">MEDICAL</td><td>General Practitioner:</td><td rowspan="4">Other Treatment Providers:</td></tr>
<tr><td>Address:</td></tr>
<tr><td>Phone:</td></tr>
<tr><td>Fax:</td></tr>
</table>

<table>
<tr><td rowspan="3">EMPLOYMENT</td><td colspan="2">Occupation:</td></tr>
<tr><td>Employer:</td><td>Address:</td></tr>
<tr><td>Contact Person:</td><td>Phone:</td></tr>
</table>

<table>
<tr><td rowspan="2">LAWYER</td><td>Name:</td><td>Firm:</td></tr>
<tr><td>Address:</td><td>Phone:</td></tr>
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SERVICE REQUEST

- ☐ Activity Re-activation Counselling
- ☐ Complex Case Management/ Disability Management Consulting
- ☐ Cognitive Demands Analysis (CDA)
- ☐ Cognitive Rehabilitation Services/ Remedial Strategies
- ☐ Cognitive Screening
- ☐ Discharge planning
- ☐ Ergonomic Assessment
- ☐ Job Site Analysis (JSA)
- ☐ OT Home Visit/ In-home Functional Assessment
- ☐ Pain Management
- ☐ Task Assignment: Meet with client _____ Family Physician_____ Other______
- ☐ Transferable Skills Analysis (TSA)/ Employability Assessment
- ☐ Vocational Counselling
- ☐ Other (please specify): _____

Signature: ____ Date: ______________________________

Please print and fax to (855) 482-3967
P.O. Box 48118, Bedford, NS B4A 3Z2