

Fax: 416-599-1530 or 1-888-399-4555
Date: _____

From:

Name _____ Company _____ Location _____

Telephone _____ Fax _____ E-mail _____

Principal Contact (if different from above): Name _____ Company _____

Location _____ Telephone _____ Fax _____

Is this a reassessment Yes No **Is this claimant** Male Female

Service(s) Required: **CONFIRMATION OF APPOINTMENTS TO BE PROVIDED BY** Fax Courier/Mail E-mail

 Functional Capacity Evaluation Job Site Analysis OT In-home Assessment Post Job Offer Screening Vocational

 Independent Medical Evaluation / Insurer's Examination File Review Video Review **In the following specialty(ies):**

- | | | |
|---|--|---|
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Dentistry/Oral Surgery |
| <input type="checkbox"/> Family Medicine (GP) | <input type="checkbox"/> Geriatric Medicine | <input type="checkbox"/> Internal Medicine |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Neuropsychiatry | <input type="checkbox"/> Neuropsychology |
| <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Occupational Medicine |
| <input type="checkbox"/> Oncology | <input type="checkbox"/> Ophthalmology | <input type="checkbox"/> Orthopaedic Surgery |
| <input type="checkbox"/> Otolaryngology(ENT) | <input type="checkbox"/> Physiatry | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Psychology | <input type="checkbox"/> Respirology |
| <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Urology | <input type="checkbox"/> Other: |

Supplementary services to be arranged by Riverfront:
 Diagnostics/Testing _____ **Translator** _____ **Transportation** **Accommodation**
Examinee (Claimant) Information:

| | | | | |
|-----------|------------|---------------------------------|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| Last Name | First Name | Date of Birth: (mm / dd / yy) | | |

| | | |
|---------|---------------|-------------|
| _____ | _____ | _____ |
| Address | City/Province | Postal Code |

| | | | | |
|-----------|-------------------|---|-------|-------|
| _____ | _____ | _____ | _____ | _____ |
| Telephone | Claim/Reference # | Date of Loss/Disability: (mm / dd / yy) | | |

Counsel or Representative: (Note: Confirmation of appointments will be sent to the examinee and their representative unless otherwise directed)

| | | |
|-------|-------|----------|
| _____ | _____ | _____ |
| Name | Firm | Location |

| | | |
|-----------|-------|------------|
| _____ | _____ | _____ |
| Telephone | Fax | File/Ref # |