# Employee being referred:

Name:

Date of Birth:

Phone:

Email:

# Company Name & Address (Employees’ Location):

Address:

Employee’s Manager:

Phone:

Email:

# Name of company / contact coordinating accommodations:

Name:

Phone:

Email:

# Billing Contact:

Name:

Address:

Phone:

Email:

**Who should be contacted to coordinate scheduling of appointments?**

Employee Directly Employees’ Manager Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you require a report? Yes**   **No**

**If yes, who should the report be copied to?** (Check all that apply)

Employee

Billing Contact

Employee’s Manager

Company/Contact coordinating accommodations

**Vocational Goal** (e.g., Return to work – same position, similar position, different position; improve productivity; training/orienting on current known AT to assist with work performance, etc.):

**Assistive Technology (AT) Needs (if known)**

**Desired outcomes of assessment** (e.g., determine what AT will assist with returning client back to work/ improve productivity, determine what job duties can be accommodated with the use of assistive technology, etc.):

**Please provide the following documentation referral**

1. Medical information supporting employee’s disability
2. Employee’s job description

By signing below, you agree to the consultation rate of $140/hr + HST (for initial assessment, equipment trials, reporting), with travel time being billed at a lower rate of $80/hr + HST, and relevant travel costs. If necessary, please provide maximum billable amount approved for consultation without seeking prior approval $\_\_\_\_\_\_\_\_\_\_.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_