MOUNT SINAI HOSPITAL
FUNCTION AND PAIN PROGRAM

Treatment Referral Form

PLEASE NOTE: ALL WSIB REFERRALS SHOULD BE SUBMITTED THROUGH THE TELUS PORTAL

Referral Date: _____ **Claim Number:** _____

Claimant			
Surname		First Name *(Mr., Mrs., Ms., Miss)*	
Address		Job Title	
City	Postal Code	Telephone ( )	Date of Birth **D/M/Y**
Injury Date **D/M/Y**		Language Barrier? ☐ Yes ☐ No	

Referred By:		
Surname	First Name	
Address	Telephone ( )	Facsimile ( )
Title	Email Address:	

Family Doctor:		
Name	Telephone ( )	Facsimile ( )
Address		

Funding Information:		
Company Name	Contact Person	
Address	Telephone ( )	Facsimile ( )

Lawyer:		
Company Name	Contact Person	
Address	Telephone ( )	Facsimile ( )

Nature of Problem/Goals/Special Issues:

Medical Information ☐ **Faxed** ☐ **Mailed**	**Job Description**	☐ **Faxed**	☐ **Mailed**
	Work Status	☐ **Part Time**	☐ **Not Working**

Mount Sinai Hospital ☐
1183-600 University Ave.
Toronto, Ontario M5G 1X5
(College Street & University Ave.)
PLEASE FAX THIS FORM TO (416) 586-4658
Tel: (416) 586-4800 ext. 5473