Odyssey Health

ODYSSEY HEALTH REFERRAL FORM

Version August 2025

DATE OF REFERRAL	Month:	Day:	Year:
WHICH SERVICE ARE YOU REQUESTING?	☐ Psychological Assessment (Potential Long-Term Treatment - Excursion or Expedition)		
	☐ Psychological IME (No Treatment)		
	☐ Express Program (Short Term)	☐ Screening	☐ No Screening
	☐ Unsure. Please contact me.		
NAME OF CONTACT			
ORGANIZATION			
PHONE NUMBER		**FAX NUMBER**	
EMAIL ADDRESS			
CLIENT LEGAL NAME (First, Initial, Last)			
CLIENT PREFERRED NAME (First, Initial, Last)			
CLIENT PRONOUNS	☐ She/Her	☐ He/Him	☐ They/Them
	☐ Prefers not to say	☐ Let me enter	
FULL ADDRESS (Street, Unit, City, Province, Postal Code)			
HOME PHONE #		**MOBILE PHONE #**	
EMAIL ADDRESS			
DATE OF BIRTH	Month:	Day:	Year:
DATE LAST WORKED	Month:	Day:	Year:
CHANGE OF DEFINITION DATE	Month:	Day:	Year:
CURRENT DEFINITION OF DISABILITY		**GAINFUL LEVEL ($)**	
% OF PRE-DISABILITY SALARY			
POLICY #		**EMPLOYEE #**	
PORTFOLIO #		**CLAIM #**	
PRIMARY PHYSICIAN			
PHONE #		**FAX #**	
NAME OF EMPLOYER			
POSITION			
CONTACT PERSON			
PHONE #		**FAX #**	
IS THERE A JOB TO RETURN TO?	☐ YES	☐ NO	☐ UNSURE
ARE WE RETURNING THIS INDIVIDUAL TO THEIR OWN OCCUPATION?	☐ YES	☐ NO	☐ UNSURE
LITIGATION CURRENTLY INVOLVED	☐ YES	☐ NO	☐ UNSURE
OTHER COMMENTS			
ALL MEDICAL DOCUMENTATION FOR THIS FILE IS INCLUDED			☐ YES

PLEASE RETURN THIS FORM by EMAIL to Intake@odysseyhealth.ca or by FAX to 905-390-3017

or through our SecureDocs Link