Send this form to the appropriate insurer

Fax # (____)______-__________

and Health Care Practitioner

Referral to:
- ☐ **Primary Health Care Practitioner**
- ☐ **Injury Management Consultant**
- ☐ **Other ____________________**

Referral Form (Form NS-5)

Use this form for accidents that occur on or after April 1, 2013.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner	
Insurance Company	
Policy Number:	
Date of Accident: (DD MM YYYY)	

Section 1: Claimant Information

Part 1

Claimant Information

Date Of Birth (YYYYMMDD)	Gender ☐ Male ☐ Female	Telephone Number
Last Name	First Name	Middle Name
Address		
City, town or county	Province	Postal Code
Representative (if applicable)	Address	
Telephone Number (Include area code)	Fax Number (Include area code)	

Part 2

Information of Primary Health Care Practitioner who is Referring the Claimant

Name of Professional (Please Print)	Profession	
Address		
City, town or county	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

Part 3

Information of Professional to whom Claimant is being Referred

Name of Professional (Please Print)	Profession	
Address		
City, town or county	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

Final approved copy

Section 2: Summary of Injury and Treatment

(To be completed by the Primary Health Care Practitioner)

Part 4 **Reason for the referral**	Opinion requested for: ☐ Definitive diagnosis ☐ Treatment
Part 5 **Details of the injury investigations and treatment to date**	
Part 6 **Information Enclosed**	I am enclosing the following relevant information (e.g., consent form, reports of investigation including laboratory analysis, diagnostic imaging, or other reports):
Part 7 **Signature of Primary Health Care Practitioner**	Signature ____________________ Date____________

Final approved copy

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