You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Important Notice About Your Personal Information

Send this form to the appropriate insurer

Fax #

and Health Care Practitioner

Referral Form (Form AB-5)

Use this form for accidents that occur on or after October 1, 2004.

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)	

Referral to:

- ☐ **Primary Health Care Practitioner**
- ☐ **Injury Management Consultant**
- ☐ **Other** _____

Section 1: Claimant Information

Part 1 Claimant Information

Date Of Birth (DD-MM-YYYY)	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		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		Profession
Address		
City, town or county	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

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_____

Reset Form Print Form