MINDFUL CONNECTIONS
Therapy

1100 Sheppard Avenue East, Unit 407, North York, ON · (647) 983-6940 · contact@mindfulconnectionstherapy.ca

MVA Client Referral Form

Motor vehicle accident referrals from physicians, lawyers, case managers, and OT and rehab providers

Thank you for your referral. Please complete this form, save it, and email it to contact@mindfulconnectionstherapy.ca. Fields marked * are needed for us to confirm the claim with the insurer. Our office will contact the client to arrange next steps and confirm with you once we have been in touch. This form is not for emergencies. If the client is in crisis, they should call 911 or go to the nearest emergency department.

1. REFERRAL SOURCE

Referred by: ☐ Physician ☐ Lawyer / law clerk ☐ Case manager ☐ OT / rehab company ☐ Other

Name * | **Profession / title**

Organization / firm | **Date of referral** | **Your file / reference no.**

Phone * | **Email *** | **Fax**

2. CLIENT INFORMATION

Client name * | **Date of birth (DD/MM/YYYY) *** | **Preferred language**

Phone * | **Email** | **Best time to reach**

Address (as it appears on the claim)

Client prefers: ☐ In person (North York) ☐ Online ☐ No preference

Client is aware of this referral and agreed to be contacted: * ☐ Yes ☐ No

3. ACCIDENT AND CLAIM

Date of accident * | **Auto insurer *** | **Claim number ***

Policy number * | **Policy holder (if not the client)**

Adjuster name | **Adjuster phone** | **Adjuster email**

Client was the: ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist ☐ Other

Minor Injury Guideline: ☐ In the MIG ☐ Removed from the MIG ☐ Unknown

OCF-1 submitted: ☐ Yes ☐ No ☐ Unknown

Extended health benefits: ☐ Yes ☐ No ☐ Unknown

MVA Client Referral Form (continued)

4. LEGAL REPRESENTATION AND REHAB TEAM

Represented by a lawyer: ☐ Yes ☐ No

Law firm | **Lawyer / law clerk** | **Phone or email**

Case manager / OT (if any) | **Company** | **Phone or email**

5. REASON FOR REFERRAL

Concerns since the accident (check all that apply)

☐ Anxiety / panic ☐ Driving or travel anxiety ☐ Trauma / PTSD symptoms ☐ Low mood / depression

☐ Sleep problems ☐ Concussion / brain injury ☐ Coping with pain ☐ Other

Service requested

☐ Psychotherapy ☐ Psychological assessment ☐ Pre-screen for assessment ☐ Not sure, please advise

Brief description of the referral question and current symptoms

Any safety concerns we should know about (e.g. thoughts of self-harm, risk to others)

6. OTHER CARE

Family physician | **Clinic** | **Phone or fax**

Current treatment and providers (e.g. physiotherapy, chiropractic, psychiatry, medication)

Documents attached (optional)

☐ Physician's note or referral ☐ Prior reports ☐ Insurer correspondence ☐ Client consent / direction ☐ Other

7. CONSENT AND SIGNATURE

By sending this referral, I confirm that the client has agreed to this referral and to Mindful Connections Therapy receiving the information on this form. Lawyers: please attach the client's signed consent or direction so we can communicate with your office about the file.

Referrer name | **Signature (typed is fine)** | **Date**

How to send

Save the completed form and email it to contact@mindfulconnectionstherapy.ca.
Please put a client code or initials in the subject line, not the client's full name.
Questions? Call (647) 983-6940.

ABOUT OUR MVA PROGRAM

FSRA-licensed service provider. We bill auto insurers directly through HCAI under the SABS. Treatment plans (OCF-18) are prepared by our team, and psychological assessments are completed by our psychologists. With the client's consent, we coordinate with their lawyer, case manager and rehabilitation team. In person in North York and online across Ontario. Multilingual team: see our website.

A space to heal, learn and grow.