



Active Rehabilitation Services

Fax to: 778.327.9144

ICBC \_\_\_\_\_

Today's Date: \_\_\_\_\_

Other \_\_\_\_\_

Claim Number: \_\_\_\_\_

Patient

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Ph. #: \_\_\_\_\_

\_\_\_\_\_ Fax #: \_\_\_\_\_

Legal Counsel

Lawyer's Name \_\_\_\_\_

Firm Name: \_\_\_\_\_ Ph. #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Medical Personal

Physician's Name: \_\_\_\_\_ Approved by Physician: Yes No

Address: \_\_\_\_\_ Ph. #: \_\_\_\_\_

\_\_\_\_\_ Fax #: \_\_\_\_\_

Others: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Injury

Referral Date: \_\_\_\_\_ Injury Area: \_\_\_\_\_

Intake Date: \_\_\_\_\_

DOI: \_\_\_\_\_

Work

Employed: Yes No

Employer Name: \_\_\_\_\_ Supervisor \_\_\_\_\_

Address \_\_\_\_\_ Ph. #: \_\_\_\_\_

\_\_\_\_\_ Fax #: \_\_\_\_\_

Insurance Adjuster

Name: \_\_\_\_\_ Ph. #: \_\_\_\_\_

Office Location: \_\_\_\_\_ Fax #: \_\_\_\_\_

\_\_\_\_\_ e-mail: \_\_\_\_\_