

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)	

Summary of Injury and Treatment

Section 2:

(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 _____