

MCARETX

Notification of Intake for Secondary or Tertiary Treatment Program

Fax to: Workers' Compensation Board 306.787.4311 or 1.888.844.7773

Treatment information

Name of treatment centre: _____

Clinic phone number: _____

Treatment clinic number (*i.e., PHY, HSP*): _____

Treatment level (*please check one*):

Secondary

Tertiary

Referred by: _____

Program will begin on: _____

Referral date from WCB/primary caregiver: _____

Patient information

WCB claim number: _____

Personal health number: _____

Name of patient: _____

Expected treatment schedule

Five days per week

Other *Please specify:* _____

Signature

Date