Return this form to:

Designated Assessment Referral (OCF-11A)

DO NOT WRITE HERE	Claim Number
	Policy Number

Use this form for accidents that occur on or after January 1, 1994. Parts 1 through 6 must be completed and signed by the insurance company. The referral will not be accepted unless all the information is complete.

Part 1 Applicant Information

Last Name	First Name and Initial			
Address			Date of Accident	year month day
City	Home Telephone	Area Code	Province	Postal Code

Part 2 Insurance Company Information

Name of Insurance Company			
Name of Insurance Company Representative			Title
Address			
City		Province	Postal Code
Telephone Number	Area Code	FAX Number	Area Code

Part 3 Designated Assessment Centre

Name of Designated Assessment Centre			
Address			
City		Province	Postal Code
Telephone Number	Area Code	FAX Number	Area Code

Is this the nearest DAC to the insured person's residence that is authorized to assess the impairment(s) sustained and to conduct the type of assessment required?

☐ Yes

☐ No, because the nearest DAC
- ☐ has declared a conflict of interest
- ☐ is unable to meet the 2 week intake time line
- ☐ is over 100 kms. from the claimant's residence

☐ other, please explain _____

Part 4 Type of Assessment

☐ This is a catastrophic impairment assessment. (Bill 59 only)

☐ This is a disability assessment for a person claiming:
- ☐ Income Replacement Benefits
- ☐ Income Replacement Benefits - post-104 weeks (Bill 59 only)
- ☐ Caregiver Benefits
- ☐ Non-Earner Benefits (Bill 59 only)
- ☐ Education Disability Benefits (Bill 164 only)
- ☐ Disability Benefits (Bill 164 only)

☐ This is a medical/rehabilitation assessment.
The goods and services in dispute include: _____

☐ This is an attendant care assessment

Part 5 Referral Question(s)

Part 6 List of Documents Forming Referral Package

List of documents forming referral package (for example: medical reports, clinical notes and records, surveillance video tapes, and test results). Attach index of medical brief (if available).

NB: **It is the claimant's responsibility to advise the Designated Assessment Centre of any other documents not listed which may be useful in completing the assessment.**
See Part 7.

I certify that I have included all relevant information necessary for the assessment.

Date **Signature of insurer representative**

Part 7 List of Documents from Claimant

List any documents you do not see listed above and you wish to be included for the assessment. Attach copies if available.
(To be completed by claimant and sent to the Designated Assessment Centre before the assessment appointment if possible)