
Chartis Medical & Rehabilitation Limited Referral Form

REFERRER DETAILS

Company: _____ Date: _____
Name: _____ Phone: _____
Address: _____ Fax: _____
_____ Email: _____

INJURED PARTY DETAILS

Name: _____ Date of Birth: _____
Position: _____ Home Phone: _____
Home Address: _____ Email: _____
Work Address: _____ Work Phone: _____
_____ Work Fax: _____

INSURED DETAILS

Insured Name _____

INJURY AND CLAIM DETAILS

Date and Time of Incident: _____

Brief description of incident:

Description of injury/illness/condition:

Description of ongoing symptoms if known:

Detail any time off work due to the accident/ illness?

Does the claimant have legal representation? Yes No

If 'yes', please provide the contact details of their solicitor:

ADDITIONAL COMMENTS

Do you have any specific requests with regard to this person's injury/ illness?

Do you have any other comments?

Are you happy for Chartis MR to open a file & assist with rehabilitation? **Yes** **No**

Details of company responsible for paying accounts to Chartis MR (name, address, phone contact & reference number) – (if via Accel Elite policy please advise & also details of your accounts department):

SIGNED : _____(Referrer)

DATED: _____

Thank you for taking time to complete this form, please keep a copy for your records and return the original to:

**Chartis Medical & Rehabilitation Limited,
The Chartis Building
2-8 Altyre Road,
Croydon
Surrey
CR9 2LG
Tel: 020 7954 7375**

Or alternatively fax the completed form to
FAX: 020 7954 7744