Referral Form

Referral Type: ☐ **New Evaluation** ☐ **Re-evaluation** ☐ **Review**

IME IRE FFD Perm. Eval 2nd Opinion FCE other: ______ | Act 6 Peer Review File Review Film Review

Referral Date: ______ Intake method: ☐ IMX pickup

Appointment needed by: ______ Report needed by: ______ Intake by: ______

Claimant Name:	Injury Date: Jurisdiction:
Address:	Injury to be evaluated:
Address:	Is injury accepted? (circle): yes no
Phone: ( )	Other complaints:
Social Security #:	Treating provider:
Date of Birth:	Employer: Occupation:
Case type (circle): Comp Auto Liab. Disab. Other:______	Provider Specialty Requested:
Referred by:	**Bill To:** Claim #:
e-mail address:	**e-mail address:**
Company:	Company:
Address:	Address:
Address:	Address:
Phone: Fax:	Phone: Fax:
Defense Attorney:	**Plaintiff Attorney:**
e-mail address:	**e-mail address:**
Firm Name:	Firm Name:
Address:	Address:
Address:	Address:
Phone: Fax:	Phone: Fax:

Special Instructions- IME will address Diagnosis, Prognosis, Present Disability, History of Injury and Medical Treatment, Prior Injuries, Pre-Existing Conditions and:

- ____ Causal Relationship between injury and current complaints
- ____ How could the injury/accident have caused complaints?
- ____ Further treatment needed? If so, what type
- ____ Is treatment reasonable and necessary and related to the accepted injury
- ____ Has claimant recovered from this injury? If so, complete a Physician's Affidavit of Recovery
- ____ Has claimant reached maximum medical improvement?
- ____ Periods of total and partial disability
- ____ Can Claimant return to work at this time? If not, why?

- ____ What are claimant's physical capabilities?
- ____ Permanency Rating
- ____ Any loss of function?

For Disability Cases:

- ____ Can Claimant Perform Duties of his/her **OWN** Occupation?
- ____ Can Claimant Perform Duties of **ANY** Occupation?
- ____ Both of above

Are X--rays Authorized?: ☐ Yes ☐ No If yes, max amount authorized? ______

Fax Impression?: ______ Phys. Caps?: ______ Affidavit?: ______

Automatically reschedule no show (circle):**yes no**

Coordinate: transportation- yes no translation- yes no

Send Confirmation: ☐ Yes ☐ No

Letter To: ☐ Clmt. ☐ Clmt. Atty

Copy To: ☐ Clmt. ☐ Ref. Source ☐ Clmt. Atty ☐ Def Atty

Other : ______

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