



Freehold, NJ (800)257-1463 fax (877)675-4465
Burlington, MA (800)392-6462 fax (781)906-6365
Carrollton, TX (800)676-3480 fax (800)797-8760

REFERRAL DATE		WCB# (New York W/C ONLY)		ASM (NAME & CONTACT #)					
CLAIMANT				PAYOR/ADJUSTER NAME and E-MAIL					
ADDRESS				COMPANY					
CITY & STATE				ADDRESS					
PHONE		FAX		CITY & STATE					
D.O.B.		S.S. #		PHONE		FAX			
CLAIMANT OCCUPATION				FILE #		INSURED			
TYPE OF INJURY		DATE OF INJURY	JURISDICTION	W.C.	LIABILITY	AUTO	NO FAULT	LTD/STD	OTHER
CLAIMANT ATTORNEY				RUSH EXAM? <input type="checkbox"/> yes <input type="checkbox"/> no			NEEDED BY?		
ADDRESS		PHONE		RE-EXAM? <input type="checkbox"/> yes <input type="checkbox"/> no			DATE OF LAST EXAM?		
City State		FAX		HCP Re-exam Name:					
Treating Physician				TRANSPORTATION NEEDED? <input type="checkbox"/> yes <input type="checkbox"/> no			INTERPRETER NEEDED? <input type="checkbox"/> yes <input type="checkbox"/> no		
Address				X-RAY AUTHORIZATION? <input type="checkbox"/> yes <input type="checkbox"/> no		REFERRAL TYPE			
City State						IME___ PEER___ Record Rev___			

SPECIALTY

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Physical Medicine & Rehab(PMR). |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Cardiologist |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Surgeon |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Internist |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Other | <input type="checkbox"/> Dentist |

SPECIFIC INSTRUCTIONS

- | | |
|--|--|
| <input type="checkbox"/> 1. Diagnosis | <input type="checkbox"/> 8. Can claimant return to work at this time? If not, when ? |
| <input type="checkbox"/> 2. History of injury and subsequent medical treatment | <input type="checkbox"/> 9. Permanency rating |
| <input type="checkbox"/> 3. Prior injuries and/or pre-existing conditions | <input type="checkbox"/> 10. Has claimant returned to pre-accident status? |
| <input type="checkbox"/> 4. Causal relationship to conditions | <input type="checkbox"/> 11. Has claimant reached maximum medical improvement? |
| <input type="checkbox"/> 5. Present disability and degree of disability | <input type="checkbox"/> 12. Schedule Loss of Use |
| <input type="checkbox"/> 6. Further treatment needed? If so, frequency and duration? | <input type="checkbox"/> 13. M&S 15/8: |
| <input type="checkbox"/> 7. Need for surgery | |

SPECIAL INSTRUCTIONS

Cc: Defense Counsel (please include specific atty name, firm and complete address, tel/fax#)	cc: Nurse Case Manager (please include name, address, tel/fax#)
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I.M.E. PHYSICIAN	LOCATION	EXAM DATE	EXAM TIME
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