

Referral Form



EVALUATIONS

Independent Medical Evaluation: _____
Permanency Evaluation: _____
Impairment Rating Evaluations (PA): _____
Fit For Duty Evaluation: _____
2nd Medical or Surgical Opinion: _____
Impairment Rating Determination: _____
(Which State) _____
Functional Capacity Evaluation: _____

RECORD REVIEWS

Act 6 Peer Review (PA): _____
Medical Record Review: _____

Referral Date: _____ **Intake method:** Fax Regular mail E-mail IMX pickup
Appointment needed by: _____ **Report needed by:** _____

Claimant Name: _____	Date of Injury: _____	Jurisdiction: _____
Address: _____	Injury to be evaluated: _____	
Address: _____	Accepted Diagnosis: _____	
Address: _____	Is Injury accepted? (circle): _____	
Phone: () _____	Other complaints: _____	
Social Security #: _____	Treating provider: _____	
Date of Birth: _____	Employer: _____	Occupation: _____
Case type (circle): Comp Auto Liab. Disab. Other: _____	IME Provider Specialty Requested: _____	

Referred by:	Bill To:
Name: _____	Claim#: _____
Company: _____	Company: _____
Address: _____	Address: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Email Address: _____	Email Address: _____

Defense Attorney Name:	Plaintiff Attorney Name:
Firm Name: _____	Firm Name: _____
Address: _____	Address: _____
Address: _____	Address: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Email Address: _____	Email Address: _____

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 & current complaints.
 How could the injury/accident have caused complaints?
 Further treatment needed? If so, what type
 Is treatment reasonable, necessary and related to accepted injury?
 Has claimant recovered from their 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?
 Other areas to be addressed (see below)

For Disability Cases:

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