Referral form

IMPAIRMENT SOLUTIONS™

EMAIL: CHRIS@EMEINTL.COM
PHONE: 800-639-1244
Cell: 781 771 3101
Fax to: 781 367 4340

Date of Request:	☐ Rush
Service Requested	
☐ Impairment Rating Audit/review	☐ Custom request:
☐ Estimated Impairment Rating (no IR included)	
☐ AMA Giudes 4th 5th 6th	
Insurance	
☒ Workers Comp ☐ Disability ☐ Auto accident Personal Injury	

Email receipt of referral sent within 48 hours

Requesting Party			
Customer			
Company:			
Address:			
City:			
State:			
Phone:			
Fax:			
Email:			

Claim Information	
First Name:	
Last Name:	
Claim Number:	
Date of Birth:	
Date of Injury	
Claim Jurisdiction:	
Address:	
City:	
State/ Zip Code	
Employer:	
Occupation:	
Job Function:	

Medical Audit needs

☐ Prognosis (estimated RTW)

☐ Provide an MMI Date

☐ Causal Relationship of Injury

☐ Verify Diagnosis

☐ Identify Restrictions of ADL (activities of daily living)

☐ Apportionment (what % of injury is job related)

Injury Information	
Compensable Body Part(s):	
Diagnosis:	
Diagnosis:	

Additional Comments