|  |  |  |  |
| --- | --- | --- | --- |
| 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: |  | | |

|  |
| --- |
| **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) |

|  |  |
| --- | --- |
| **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: |  |
|  |  |

|  |  |
| --- | --- |
| **Injury Information** | |
| Compensable Body Part(s): |  |
| Diagnosis: |  |
| Diagnosis: |  |
|  |  |
| **Additional Comments** | |
|  | |