|  |  |  |
| --- | --- | --- |
| Date of Request: |  | **[ ]** Rush |
| **Service Requested** |
| [ ]  Impairment Rating Audit/review | [ ]  Custom request: |
| [ ]  Estimated Impairment Rating (no IR included) |  |
| [ ] AMA Giudes 4th 5th 6th  |  |
| **Insurance**  |
| [x]  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** |
|  |