



**Workers Compensation
Independent Medical Examination Referral Form**

DATE:	
RE EXAM:	
HEARING DATE:	

REFERRAL SOURCE:

Name: _____ Email Address: _____
 Company: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Telephone Number _____ Extension: _____ Fax: _____

CLAIM INFORMATION:

Examinee Name: _____ S.S.#: _____
 Address: _____
 Telephone Number(s) _____
 Transportation or Interpretation Needs: _____ Date of Birth: _____
 Employer: _____ Claim Number: _____
 WCB Number: _____ WC City: _____
 Nature of Injury: _____ Date of Injury: _____

TREATING PROVIDER:

Name: _____ Specialty: _____
 Address: _____
 Phone: _____ Fax: _____

ATTORNEY:

Name: _____ Law Firm: _____
 Address: _____
 Phone: _____ Fax: _____

IME/EXAM TYPE:

- Orthopedic Neurosurgery Neurology Occ Health Chiro
- PMR: Pain Mngt: Psych: Functional Capacity Evaluation
- Other: _____

OBJECTIVE OPINION NEEDED ON:

- Diagnosis/Prognosis M&S statement (15-8) Review job description Need for surgery?
- Degree of disability Casual relationship to injury Ability to rtw/light duty? Apportionment?
- History of injury/prior medical hx Further treatment needed? Restrictions?
- Maximal medical improvement Frequency/duration for treatment? Permanency/SLU

ADDITIONAL COMMENTS:

Workplace Health Solutions Use Only:

Physician/Provider: _____ Location: _____
 Date: _____ Time: _____ am pm