

REFERRAL FORM

DATE SUBMITTED: _____

How would you like to receive the report? Email Fax Mail Phone

Requesting Party Information		
Name:		
Company:		
Address:		
City:		
State:		Zip:
Phone:		Ext:
Fax:		
Email:		

Patient Information	
Name:	
Address:	
City:	
State:	Zip:
S.S. #:	
DOI:	
DOB:	
Claim #:	
WCAB #:	
Occupation:	
Employer:	
Please provide a job analysis if job is outside the norm	

Service Requested:
<input type="checkbox"/> Impairment Rating Review Review of IR with brief summary per AMA Guides
<input type="checkbox"/> Disability Rating - PDR Per CA PDRS 2005
<input type="checkbox"/> Consultation Phone conference
<input type="checkbox"/> Impairment Rating Calculate IR when no IR was provided
* Note: For Disability Rating
Number of employees:
Was a job offered?
Average weekly wage:

Compensable Regions / Diagnosis (list):
1.
2.
3.
4.

Review to be done by:
<input type="checkbox"/> Let Impairment Solutions choose
<input type="checkbox"/> MD Review (higher fees apply)
<input type="checkbox"/> Chiropractor

Comments / Instructions:
