Referred By Date: _____ **IME**_____ **Peer/Record/Film Review**_____ **Disability**_____ **Michigan IME #**_____

Company: _____ Client Name: _____

Address: _____

Phone: _____Fax: _____ Email: _____

Claimant Name: _____

Claimant Address: _____City:_____ State: _____ ZIP: _____

Claimant Phone: _____ _____

Claimant Date of Birth: _____ Claimant Date of Loss: _____

Social Security Number: _____ W/C_____ Auto_____ STD_____ LTD_____ FMLA_____Liability_____

Injury/Allegation: _____TAT:_____ RUSH_____ Cite Certified_____ No Cite_____

Claim Number: _____

Issues to Be Addressed:

Causal Relationship_____ Need for Treatment, Type, and Duration_____

Ability to Return to Work_____ Treatment Reasonable, Necessary, Appropriate_____

Degree of Disability_____ Current Medical Status_____ Pre Existing Condition_____ Diagnostics Pre-Approved: Yes or No

Special Instructions: _____

_____

_____

_____

Litigated: Yes: _____ **No:** _____

Claimant Attorney Information:

Name: _____ Email: _____

Address: _____Phone:_____Fax:_____

Defense Attorney Information:

Name: _____Email: _____

Address: _____ Phone: _____ Fax: _____

Transportation: _____ Translation: _____

Medical Records: Pick UP_____ **Copy**_____ **Email**_____ **Mail** _____ **Fax**_____

Doctor or Specialty Requested: _____**Date:**_____**Time:**_____

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