Company Care
5000 N. 26th Street, Suite 200
Lincoln, NE 68521
(402) 475-6656

Referral Form

IME Medical File Review Workers Compensation Liability LTD Other: _______________

Request Date: ________________________________

EXAMINEE INFORMATION

Name: ____ Soc. Sec. #:____________________________________

Address: ____ Date of Birth: __________________________________

City: _____________________State:_____Zip:____________ Phone: _______________________________________

Job Title: ____

Date of Injury: _______________________________________ Type of Injury: _________________________________

Employer at Time of Injury: ____________________________ Attending Physician: _____________________________

Employer Address ____________________________________

Employer City _______________ State _______ Zip _______

EXAMINEE ATTORNEY INFORMATION

Atty Name: ____

Firm Name: ____ Phone: _______________________________________

Address: ____ Fax: ____

City: ____ State: ________________ Zip: ____________________

CLIENT INFORMATION

Name: ____

Company: ____

Address: ____

City: ______________________State:_____Zip:____________

Phone: _________________________Fax:_________________

Claim #: ____

BILLING INFORMATION Same as Client

Name: _______________________________________

Company: ____________________________________

Address: _____________________________________

City: ____________________State: _____Zip: _______

Phone: _________________Fax: __________________

Claim #: ______________________________________

ISSUES TO BE ADDRESSED IN REPORT:

Diagnosis
Causal Relationship
Prognosis
Work Capacity Rating
Review of Enclosed Job Description
Maximum Medical Improvement
Permanent Impairment Rating
Appropriateness of Care
Recommendations
Answers to questions on accompanying letter
Other ________________________________
____

APPOINTMENT AND REPORT INFORMATION

Send copy of report to:
Client Billing party (if different from client) Examinee attorney
____

Medical records are enclosed to follow unavailable.

Appointment Date: ____________________ Time: _________ Physician: __________________________________

FAX OR MAIL THIS COMPLETED FORM, ALONG WITH MEDICAL RECORDS TO COMPANY CARE FAX (402) 742-8419.