Referral Form

Impairment *Solutions*™

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Date of Request:	☐ Rush
Service Requested	
☐ **Impairment Rating Review all editions AMA Guides**	☐ **Disability/ Impairment Evaluation**
Which AMA guides needed	
☐ **primary issue**	☐ **Complex Med Legal Review Case**
Type of Case	
☐ Specialty Case ☐ Workers Comp ☐Disability ☐Liability ☐ Auto ☐Federal	

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

Claim Information	
First Name:	
Last Name:	
Claim Number:	
Date of Birth:	
Date of Injury	
Claim Jurisdiction state:	
Employer name:	
Job Function	
Send Report to?	☐ Defense ☐ Plaintiff
Defense Lawyer:	
Email:	
Plaintiff Lawyer:	
Email:	

Primary documentation needed

What is COMPENSABLE injury that has been accepted

_____

_____

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1st report of injury
ER notes if any, clinical notes from MD/DC
All Objective testing, MRI, Cat Scan, x rays,
Operative notes ALL
Final discharge notes especially if there are PT note
With return to work information like ROM, strength etc.
Impairment Rating calculations if any
OR we will perform an estimated impairment rating based on documentation received.

Additional Comments by referral source

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