independent medical
Evaluation CONSULTANTS

888.844.0463
248.707.3991
www.IME-Consults.com

REFERRAL FORM

Date of Referral: _____

Referral Source Name: _____

Referral Source Email: _____

Service Type:

- ☐ **Independent Medical Exam**
- ☐ **Utilization Review**
- ☐ **File Review**

Choose a medical specialty from the drop-down menu; enter a preferred doctor's name if desired:

Medical Specialty: _____ **Preferred Physician:** _____

Let us know if you have medical records or need our assistance:

Medical Records: ☐ Included ☐ To Follow ☐ No Records ☐ Evaluation Consultants to Obtain

Claimant Information:

Full Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Last 4 Digits of SSN#: _____ **Gender:** ☐ Male ☐ Female ☐ Non-Binary

Additional Needs: (i.e. language, behavioral, physical, etc.) _____

Claim Details:

Hearing Date: _____ **Injury Date:** _____ **Report Due:** _____

Employer: _____ **Jurisdiction:** _____

Claim #: _____ **Claim Type:** ☐ Disability ☐ Auto ☐ Work Comp

Compensable Injury / Body Part: _____

Treatment Providers:

_____

Insurance Adjuster:

Adjuster Name: _____ **Company Name:** _____

Mailing Address: _____

Billing Address: _____

Office Phone: _____ **Mobile Phone:** _____

Work Fax: _____ **Work Email:** _____

Defense Attorney:

Attorney Name: _____ **Law Firm Name:** _____

Mailing Address: _____

Billing Address: _____

Office Phone: _____ **Mobile Phone:** _____

Work Fax: _____ **Work Email:** _____

Plaintiff Attorney:

Attorney Name: _____ **Law Firm Name:** _____

Mailing Address: _____

Billing Address: _____

Office Phone: _____ **Mobile Phone:** _____

Work Fax: _____ **Work Email:** _____

Nurse Case Manager:

Case Manager Name: _____ **Company Name:** _____

Mailing Address: _____

Office Phone: _____ **Mobile Phone:** _____

Work Fax: _____ **Work Email:** _____

Please complete this section only if you have requested an Independent Medical Examination (IME)

Cover Letter Questions:

COVER LETTER TO BE PROVIDED SEPARATELY

☐ Please check here if you plan to draft your own cover letter, or if it will be provided by Defense Counsel or NCM. Please provide us with a copy of the cover letter at your earliest convenience so that we may include it with the prepared medical file for the physician.

Check the box next to the item you would like the examining provider to include in the final report:

☐ Medical summary

☐ Detailed history, diagnosis, and prognosis

Check the box next to the questions you would like the examining provider to answer in their final report:

Patient History & Current Condition

☐ What is the claimant's current diagnosis based on your evaluation?

☐ Does the claimant's reported condition align with the objective medical findings?

☐ Are the claimant's symptoms consistent with the alleged injury or medical condition?

☐ Based on your review, does the medical history provided by the claimant align with the available medical records?

☐ Were there any discrepancies between the claimant's reported medical history and the medical documentation?

Causation & Injury Relation

☐ Are the claimant's current diagnoses causally related to the date of the accident?

☐ Has the treatment received been reasonable, necessary, and causally related to the date of accident?

☐ Could any pre-existing conditions be contributing to the claimant's current symptoms?

☐ Are there any underlying medical issues that could be unrelated to the claimed injury?

☐ In your opinion, would this condition have developed regardless of the reported injury or event?

Treatment & Prognosis

☐ Is the claimant's current treatment plan appropriate and medically necessary?

☐ Do you have further treatment recommendations for this claimant? If so, provide treatment plan and duration.

☐ Has the claimant reached maximum medical improvement (MMI)? If not, when do you anticipate MMI?

☐ Is continued treatment required. If so, for how long?

☐ In your opinion, are all recommended treatments reasonable and evidence-based?

Work Capacity & Disability Status

- [ ] Has the claimant fully recovered from the work injury?
- [ ] Is the claimant able to work full or light duty? Please specify necessary work restrictions and their duration.
- [ ] Are the work restrictions due to this date of injury or are they unrelated?
- [ ] If the claimant is at MMI, please provide a permanent impairment rating according to the AMA Guidelines.
- [ ] Please apportion your rating to include any pre-existing and/or unrelated conditions.

Future Medical Needs & Long-Term Impact

- [ ] Will the claimant require long-term medical care or rehabilitation?
- [ ] Is the claimant at risk for further complications or deterioration of their condition?
- [ ] Can the claimant eventually return to full-duty work? If so, what is the estimated timeline?
- [ ] If future medical care is required, what treatments or interventions are anticipated?
- [ ] Are there any lifestyle modifications or preventative measures the claimant should take?

Credibility & Consistency

- [ ] Did the claimant's reported symptoms and limitations appear consistent throughout the evaluation?
- [ ] Were there signs of symptom exaggeration or inconsistencies between the exam and records?
- [ ] Did the claimant fully participate in the examination, or were there any observed limitations in cooperation?
- [ ] Were any non-medical factors (e.g., psychological, social, economic) influencing the claimant's symptoms?
- [ ] Do the findings in your IME support the claimant's current disability claim, and why or why not?

Share any additional information or questions you would like the physician to address: