

# INITIAL WORKERS' COMPENSATION REFERRAL FORM

**PATIENT NAME:** \_\_\_\_\_  
Last Name First Name Middle Initial

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: M / F SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**INSURANCE COMPANY:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADJUSTER: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_

FAX: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE(S) OF INJURY: \_\_\_\_\_ NATURE OF PROBLEM: \_\_\_\_\_

NURSE CASE MANAGER: \_\_\_\_\_ PHONE: \_\_\_\_\_

AUTHORIZATIONS	Yes	No	Call
Authorized to Treat			
DME			
X-rays			
Special Studies			
Consultation Only			
Physical Therapy			
Narrative Report Requested			
Authorized to Dispense Medications			

TO BE FORWARDED	Yes	No
Medical Records		
X-rays		
Special Studies		
Interpreter Required		

APPOINTMENT IS SCHEDULED FOR: \_\_\_\_\_ @ \_\_\_\_\_ WITH DR. \_\_\_\_\_

MEDICAL/LEGAL \_\_\_\_\_

DEFENSE \_\_\_\_\_

APPLICANT \_\_\_\_\_

PANEL \_\_\_\_\_

**HEARING DATE:** \_\_\_\_\_

COMMENTS: \_\_\_\_\_

REFERRAL TAKEN BY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_