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		