Alliance Evaluation Services, LLC
Specialists in Independent Medical Evaluations
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Referral Request Form

Requestor

Date: _____

Referred By: _____ Phone: _____

Company: _____ Fax: _____

Address: _____ Email: _____

City, State Zip: _____

Nurse Case Manager: _____ NCM Contact Info: _____

Defense Attorney: _____ DA Contact Info: _____

Claimant

Name: _____ Phone: _____

Address: _____ Email (if available) _____

City, State Zip: _____

Employer/Insured: _____ Work Phone: _____

Date of Birth: _____ Social Security #: _____

Claim/File Number: _____ Date of Injury: _____

Body Part/Nature of Injury: _____

Attorney: _____ Attorney Phone: _____

Attorney Address: _____

Interpreter: Language: _____

Service

Type of Exam: Service Type:

Physician Type: Requested Physician: _____

Claim Status: Work Status:

Objectives:

Comments:

Questions

- [ ] Is the diagnosis correct and is it supported by objective findings?
- [ ] Is the current treatment reasonable and necessary?
- [ ] Is the duration/frequency of treatment appropriate?
- [ ] Is there evidence that the claimant is responding to the current treatment?
- [ ] Is surgery necessary at this time? If so, will there be a working disability?
- [ ] Are further treatment and/or diagnostic tests necessary?
- [ ] Is the diagnosis causally related to the injury or accident?
- [ ] Is the treatment related to the injury or accident?
- [ ] Is there a history of co-morbidities, prior injuries and/or pre-existing conditions that impact on the current injury or accident?
- [ ] Can claimant return to work with or without restrictions? If restrictions, please be specific and indicate anticipated duration? **Please complete attached Physical Capacity Evaluation Form.**
- [ ] Is a functional capacity evaluation recommended?
- [ ] If this is a petition to re-open, are there any new, additional or previously undiscovered condition(s) related to this injury?
- [ ] Has the claimant reached maximum medical improvement? If not, when do you anticipate maximum medical improvement?
- [ ] If the claimant is at maximum medical improvement, please give impairment rating and/or permanency rating, per AMA guidelines, if appropriate.
- [ ] If the claimant was previously given an impairment rating and/or permanency rating, does the documentation support the rating?
- [ ] Is the claimant totally or partially disabled?
- [ ] If disabled, when can the claimant return to full or modified duty?
- [ ] If stationary, do you feel supportive care is warranted? If so, please outline type, and duration of care.
- [ ] _____

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