Medical Systems Referral Form

MedicalSystems Inc.
Independent Medical Evaluation Services

Client Information:

Adjuster/Attorney
Company Name
Company Address
City/State/Zip
Phone Number *(Including Area Code)*
Email Address
IF NEW TO MEDICAL SYSTEMS, HOW DID YOU HEAR ABOUT US?

Case/Examinee Information

Case Type: ☐ Worker's Comp ☐ Personal Injury ☐ Disability	
Service Type: ☐ IME ☐ ROR ☐ FCE ☐ Limited Scope IME/PPD	Case Jurisdiction ☐ WI ☐ IL ☐ MN ☐ Other:_____
Examinee Name	Date of Birth
Examinee Address *(Address **Only if** You Wish a Confirmation Letter Sent)*	Date of Injury
City/State/Zip	Treating Physician/Facility
Phone Number *(Phone **Only if** Confirmation Call is Required)*	Employer *(Only if Worker's Compensation Case Type)*
Claim/File Number	Worker's Compensation Case Number *(If Known)*
Problems/Diagnosis(es)	Volume of Records (If Known)

Scheduling Information

Requested Specialty/Doctor	REPORT DEADLINE ***(IMPORTANT!)***
Does the requested doctor have a conflict of interest? ☐ Yes ☐ No	Scheduling Timeframe Preference