



This is a Request Form for an order of an IME in a **Workers' Compensation** case.

Part 1: Claim Information				
Date:				
	First Name	MI	Last Name	
Requested by:				
Company:				
Address 1:				
Address 2:				
City:		State:	ZIP:	
Phone:		FAX:		
e-mail:				
Name of claims adjuster:				
Claim office:				
WCB Office:				
<hr/>				
Bill to:	Requester (above)	Third Party		
Company:		Reference #:		
	First Name	Last Name		
Name:				
Address 1:		Phone #:		
Address 2:				
	City	State	Zip	
Locale:				

Part 2: Examinee Information				
	Honorific	First Name	MI	Last Name
Claimant Name:				
Claimant SSN (last 4 digits):				
Claimant Address:				
Claimant City:				
Claimant State:		Claimant ZIP:		
Claimant Phone:				

**Part 2: Examinee Information (continued)**

	Honorific	First Name	MI	Last Name
Claimant Attorney:				
Attorney Firm:				
Attorney Address:				
City:				
State:			ZIP:	
Attorney Phone:				
	Honorific	First Name	MI	Last Name
Claimant Attending Physician:				
Attending Physician Firm:				
Attending Physician Address:				
City:				
State:			ZIP:	
Attending Physician Phone:				
Claim Number:				
WCB Number:				
Date of accident:				
Employer:				

**Part 3: Examination Requirements**

If Re-examination, Prior Exam Date:			
Is this a "Rocket Docket" Controverted Case?:			
Need report by date:			
Hearing Location / City:			
ANCR:			
<b>Specialties Required:</b>			
Ortho	Neuro	Neuro Surgical	Surgeon
PMR	Psychiatric	ENT	Chiro
Internal Medical	Dental	Oral Surgery	Cardiology
Acupuncture			
Other:			

Part 3: Examination Requirements

Render Specific Opinion For:

Diagnosis	Causal Relationship
Prognosis	Need for Surgery
Further Treatment and Frequency	Permanency Rating
Degree of Current Disability	Apportionment of Disability
Has an end result / MMI been reached?	M & S Statement (2nd Injury Law)
Can claimant return to work?	Can claimant perform light / modified duty?
Scheduled Loss of Use	

Specific Job Capabilities (attach job description or include in materials for pickup)

Medical Necessity of Testing Performed (Specify test type and date below)

File Review

Film Review (List films to be reviewed below)

Special Instructions / Comments:

Attachments:

Medicals

Please schedule pickup of record materials

Other (specify below)