Peer Request - Disability

UMC Headquarters:
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EXAM TYPE:

☐STD ☐LTD ☐ABSENCE BENEFITS DATE:

REFERRAL TYPE:

☐INDEPENDENT MEDICAL EXAM (IME) ☐IME RE-EXAM ☐FUNCTIONAL CAPACITY EVALUATION (FCE)
☐IMPAIRMENT RATING ☐RECORD REVIEW ☐RADIOLOGY REVIEW OTHER:

SPECIAL INSTRUCTIONS:

☐AUTO RESCHEDULE 1ST CANC. OR NO SHOW ☐CALL TO DISCUSS CHOICES ☐PLEASE PICK-UP MEDICAL RECORDS
☐X-RAYS/DIAGNOSTICS AUTHORIZED ☐CALL FOR TESTING AUTHORIZATION OTHER:

EXAMINEE INFORMATION:		REQUESTED BY:	
FILE NUMBER:		COMPANY NAME:	
NAME:		NAME:	
ADDRESS:		TITLE:	
CITY/STATE:	ZIP:	ADDRESS:	
PHONE:		CITY/STATE:	ZIP:
SS#	DOB#	PHONE:	FAX:
EMPLOYER:		EMAIL ADDRESS:	
EMPLOYER ADDRESS:		**INJURY INFORMATION:**	
CITY/STATE:	ZIP:	DATE OF INJURY/LOSS:	
PHONE:		BODY PART(S):	
JOB TITLE:		WAGE LOSS: ☐ YES ☐ NO	

ATTENDING PHYSICIAN INFORMATION:		ATTORNEY INFORMATION:	
TREATING PHYSICIAN NAME:		ATTORNEY NAME:	
PHYSICIAN ADDRESS:		ATTORNEY ADDRESS:	
TREATING PHYSICIAN PHONE:		ATTORNEY PHONE:	FAX:
NURSE CASE MANAGER :	PHONE:	NOTIFICATION TO ATTORNEY REQUIRED: ☐ YES ☐ NO	

SPECIALTY NEEDED:

☐ORTHOPEDIST ☐NEUROLOGIST ☐ORAL SURGEON ☐PSYCHIATRIST (MD) ☐PMR
☐HAND SURGEON ☐NEUROSURGEON ☐DENTIST ☐PSYCHOLOGIST (PhD) ☐ENT
☐GENERAL SURGEON ☐ ACUPUNCTURE ☐CHIROPRACTOR ☐OPHTHALMOLOGIST ☐INTERNIST
☐PLASTIC SURGEON ☐CARDIOLOGIST ☐FCE ☐OTHER:

☐NAME OF REQUESTED IME PHYSICIAN:

ISSUES TO BE IDENTIFIED:

☐DIAGNOSIS
☐NEED FOR TREATMENT, TYPE & DURATION
☐MAXIMUM MEDICAL IMPROVEMENT
☐TREATMENT REASONABLE NECESSARY & APPROPRIATE
☐ABILITY TO RETURN TO WORK
☐JOB DESCRIPTION REVIEW
☐PROGNOSIS
☐CAUSAL RELATIONSHIP TO INJURY
☐NEED FOR SURGERY
☐PRE-EXISTING CONDITIONS
☐IMPAIRMENT RATING
☐ESTIMATED DURATION OF DISABILITY
☐SPECIFIC CAPABILITIES/RESTRICTIONS

☐OTHER ISSUES: