# IME Request - Permanency Exam

UMC Headquarters:
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**REFERRAL TYPE:**
☐INDEPENDENT MEDICAL EXAM (IME) ☐IME RE-EXAM ☐RECORD REVIEW

**SPECIAL INSTRUCTIONS:**
☐PLEASE PICK UP MEDICAL RECORDS

| CLAIMANT INFORMATION: | | REQUESTED BY: | |
|---|---|---|---|
| CLAIM NUMBER: | | COMPANY NAME: | Date: |
| NAME: | | NAME: | |
| ADDRESS: | | TITLE: | |
| CITY/STATE: | ZIP: | ADDRESS: | |
| PHONE: | | CITY/STATE: | ZIP: |
| SS# | DOB# | PHONE: | FAX: |
| EMPLOYER: | | EMAIL ADDRESS: | |
| **ATTORNEY INFORMATION:** | | **INJURY INFORMATION:** | |
| ATTORNEY NAME: | | DATE OF INJURY/LOSS: | |
| ADDRESS: | | ANCR/BODY PART(S): | |
| CITY/STATE: | ZIP: | WCB NUMBER: | |
| ATTORNEY PHONE: | FAX: | WAGE LOSS: ☐ YES ☐ NO | |

| ATTENDING PHYSICIAN INFORMATION: | ADDITIONAL PHYSICIAN INFORMATION: | |
|---|---|---|
| TREATING PHYSICIAN NAME: | PHYSICIAN NAME: | |
| ADDRESS: | ADDRESS: | |
| TREATING PHYSICIAN PHONE: | PHONE: | FAX: |

**SPECIALTY NEEDED:**

☐ORTHOPEDIST ☐NEUROLOGIST ☐ORAL SURGEON ☐PSYCHIATRIST (MD) ☐PMR
☐HAND SURGEON ☐NEUROSURGEON ☐DENTIST ☐PSYCHOLOGIST (PhD) ☐ENT
☐GENERAL SURGEON ☐PAIN MANAGEMENT ☐CHIROPRACTOR ☐OPHTHALMOLOGIST ☐INTERNIST
☐PLASTIC SURGEON ☐CARDIOLOGIST ☐OTHER:
☐NAME OF REQUESTED IME PHYSICIAN:

**HAS A PREVIOUS PERMANENT PHYSICAL IMPAIRMENT BEEN GIVEN BY A MEDICAL/IME PROVIDER PRIOR TO 01/01/2012?**

☐ YES

☐ NO

**ISSUES TO BE IDENTIFIED:**
☐DIAGNOSIS
☐CAUSAL RELATIONSHIP TO INJURY
☐DEGREE OF DISABILITY (PER WCB GUIDELINES)
☐MAXIMUM MEDICAL IMPROVEMENT
☐PERMANENCY RATING / SLU
☐ABILITY TO RETURN TO WORK

**COMMENTS:**