# Worker's Compensation Information

Initial app't date: ______________________________________ Time: ___________________________

Location: _________________________ Dr.: ______________________________________________

**Patient**'s name: (First) ____________________ (MI) ____ (Last) ______________________________

Date of birth: ____________ SS#:_________________________ Phone: ________________________

Address: ____________________________________________________________________________

**Employer**:______________________________ Employer Contact: _____________________________

Employer's phone: _________________________ Employer's Fax: _____________________________

**Carrier/TPA**: _________________________________________________________________________

Billing Address: _______________________________________________________________________

Adj's Name: ______________________________________ Claim #: _____________________________

Adj's phone _________________________ Ext. ___________ Adj's Fax: ________________________

**Date of Injury/Onset**: ____________________________ Referral Type: Please check all that apply:

______ Evaluate & Treat ______ IME _____ Hand Chart

______ Take-Over Care ______ Records Review _____ Surgery

______ Causation Opinion ______ PPI Rating

Mechanism of injury_____________________________________________________________________

_______________________________________________________________________________________

Compensable body part(s): _____________________________________________________________

Issues: _________________________________________________________________________________

_______________________________________________________________________________________

**Case Manager**:

Name: ___________________________________ Company: ___________________________________

Phone: ______________________________ Fax: _____________________________________________

**Sender's name**: ________________________________ Adjuster Case Manager Employer Other

Scheduled by: ____________________________________________________ Date: ______________