



Employee filling out referral _____

Date sent ___/___/___

Functional Abilities Evaluation ♦ Impairment Ratings/MMI ♦ Independent Medical

Examinations Phone: (210) 910 - 6653 Fax: (888) 389-8141

Patient Information

Patient _____ Date ___/___/___

Address _____ City _____ State ___ Zip Code _____

Phone (____) _____ SSN _____ Date of Birth ___/___/___ D.O.I ___/___/___

Diagnosis: _____ Area(s) of Injury: _____
(ICD-10 Codes) (Compensable only)

Insurance Information

Insurance Company _____ Phone (____) _____ Fax (____) _____

Address _____ City _____ State ___ Zip Code _____

Adjustor _____ Extension _____ Claim Number _____

Work Comp ___ Major Med ___ Personal Injury ___ Dept. Of Labor ___

Employer Information

Employer _____ Phone (____) _____

Address _____ City _____ State ___ Zip Code _____

Evaluations

___ FCE ___ PPE ___ Impairment Rating/MMI ___ Functional Assessment (PI) ___ Extent of Injury/ RTW/ Disability

FCE Assessment Request

What is the medial necessity for this functional test? Please check one or more of the following:

___ Baseline ___ If pt meets their job demands ___ If pt needs additional care ___ If pt needs tertiary care ___ Disability

Additional reason(s): _____

Physician or treating doctor certifies that the above recommended procedure(s) are medically indicated, reasonable and necessary with reference to the standards of medical practice and treatment for this patient's condition.

PCP/Treating Doctor's Signature _____ Date ___/___/___

Treating Clinic: _____ TX, _____ Phone (____) _____
Name Street

All referrals must include clients' name, DOB, ICD-10 codes, compensable regions and rationale with physicians' signature prior to scheduling. Insurance, employer and remaining demographic info may be submitted on a separate form along with the referral and job description. If an insurance verification has been/will be performed please ask adjuster and indicate how many FCE's have been performed along with IR/MMI

The PHI (personal health information) contained in this fax is *HIGHLY CONFIDENTIAL*. It is intended for the exclusive use of the addressee. It is used only in providing specific healthcare services for this patient. Any other use is in violation of Federal Law (HIPAA) and will be reported as such.

___ Insurance Verification regarding FCE/IR/MMI IS available ___ Job Description Available ___ Case is in Dispute (PLN 1 or PLN 11)