Name of person filling out this form:_____ Date __/__/___ Work Comp__ Major Med __ PI__ DOL__

Functional Abilities Evaluation ◆ Impairment Ratings/MMI ◆ Independent Medical Examinations

Phone: (469) 744-2403 Fax: (888) 389-8141 (KDTeval.com)

Patient Information

Patient _____ Phone (___)_____SSN (Last 4#) _____ DOB __/__/___ DOI __/__/___

Address _____City _____ State ____ Zip Code _____Statutory Date__/__/___

Diagnosis: _____
(ICD-10 Codes for **Compensable/Accepted conditions only**)

What was the last date of physical treatment for the patient (PT, Injection, etc.) __/__/___ What was the Tx? _____

Insurance Information

Insurance Company _____ Phone (___)_____Fax (___)_____

Address _____ City _____ State ____ Zip Code _____

Adjustor _____ Extension _____Claim Number _____

Employer Information

Employer _____ Phone (___)_____

Address _____ City _____ State ____ Zip Code _____

Evaluations

__ FCE__ PPE__ Impairment Rating/MMI (end of Tx) __Alt. MMI/IR__Functional Assessment (PI)__Extent of Injury/ RTW

Why not at MMI? ___Continued Tx expected ___ RTW Program ___Surgery ___Dr/Pt disagrees with rating or MMI date

Date of previous DD __/__/___ EOI (region and diagnosis): _____
(please send with referral) (ICD-10 Codes for **Extent Of Injury conditions only**)

Med Recs:__X-Ray__MRI__EMG__Surgical__CT__Doppler__Ultrasound__Arthrogram__Audiometry__NeuroPsych

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.

Treating Clinic name: _____ Phone (____) _____

PCP/Treating Dr's Printed Name: _____ Signature: _____

All referrals must include clients' name, DOB, last Tx, compensable ICD-10 codes & regions, rationale with Dr signature prior to scheduling.

Insurance, employer, remaining med recs and demographic info may be submitted on a separate form **IF COMPLETE** with referral and job description.

If an ins. verification has been/will be performed, please send and ask adjuster and indicate how many FCE's have been performed along with IR/MMI