Name of person filling out this form: Jessica Date 3/31/24 Work Comp X 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 MARY GOMES Phone (214)576-3546 SSN (Last 4#) 5555 DOB 01/21/74 DOI 06/01/23

Address 8392 N FOWLER AVE City DALLAS State TX Zip Code 75227 Statutory Date 06/11/25

Diagnosis: S33.5XXA - LUMBAR , S43.401A - R SHOULDER
(ICD-10 Codes for **Compensable/Accepted conditions only**)

What was the last date of physical treatment for the patient (PT, Injection, etc.) 03/07/24 What was the Tx? PT

Insurance Information

Insurance Company GALLAGHER BASSETT Phone (800) 370-0594 Fax (559) 789-3472

Address PO BOX 2934 City CLINTON State IA Zip Code 52733

Adjustor PEGGY Extension #211 Claim Number 4226-52251309

Employer Information

Employer ROCKMAN CONSTRUCTION, INC. Phone (214)333-4245

Address 123 WOODWORK AVE. City IRVING State TX Zip Code 75555

Evaluations

__ FCE__ PPE__ Impairment Rating/MMI (end of Tx) X Alt. MMI/IR__Functional Assessment (PI) X Extent of Injury/ RTW

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

Date of previous DD 2/09/24 EOI (region and diagnosis): LUMBAR - M51.16
(please send with referral) (ICD-10 Codes for **Extent Of Injury conditions only**)

Med Recs: X X-Ray X MRI X 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: HEALTH AND WELLNESS Phone (214)555-5555

PCP/Treating Dr's Printed Name: JEFF KING 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 insurance verification has been/will be performed, please ask adjuster and indicate how many FCE's have been performed along with IR/MMI