REFERRAL FORM

(800) 807-5831
(716) 626-4213
FAX (716) 626-4839

FirstChoice EVALUATIONS

APPLETREE BUSINESS PARK
2875 UNION ROAD, SUITE 8
CHEEKTOWAGA, NY 14227
www.firstchoiceevaluations.com

ADJUSTER INFORMATION

DATE OF REQUEST: _____ CLAIM #:_____ RE-EXAMINIATION: ☐
COMPANY NAME: _____ ADJUSTER E-MAIL: _____
ADJUSTER'S NAME: _____ TELEPHONE: _____ FAX: _____
ADDRESS: _____ JURISDICTIONAL STATE: _____
INSURED: _____ ADDRESS: _____
WCB CASE # (if applicable): _____ WCB LOCATION (if applicable): _____

CLAIMANT INFORMATION

EMAIL: _____ FAX: _____
CLAIMANT NAME: _____ TELEPHONE: _____
ADDRESS: _____
OCCUPATION: _____ DATE OF INJURY: _____
INJURY SITE: _____
SOCIAL SECURITY #: _____ DATE OF BIRTH: _____
APPOINTMENT LETTER TO EXAMINEE: ☐ YES ☐ NO ATTORNEY: ☐ YES ☐ NO
APPOINTMENT LETTER SENT CERTIFIED TO EXAMINEE: ☐ YES ☐ NO ATTORNEY: ☐ YES ☐ NO
APPOINTMENT LETTER SENT RETURN RECIEPT TO EXAMINEE: ☐ YES ☐ NO ATTORNEY: ☐ YES ☐ NO

TREATING PHYSICIAN

EMAIL: _____ FAX: _____
TREATING PHYSICIAN: _____ TELEPHONE: _____
ADDRESS: _____

ATTORNEY INFORMATION

EMAIL: _____ FAX: _____
ATTORNEY: _____ TELEPHONE: _____
ADDRESS: _____

TYPE OF EXAMINATION

☐ FILE REVIEW ONLY (choose specialty) ☐ ROCKET DOCKET CASE (choose specialty) ☐ ORTHOPEDIC ☐ CHIROPRACTOR ☐ NEUROLOGIST ☐ OTHER _____

☐ VARIANCE Date Variance was filed: _____/_____/_____ ☐File Review ☐IME

☐ DIAGNOSIS/PROGNOSIS
☐ DEGREE OF DISABILITY
☐ HISTORY OF INJURY/ MEDICAL TREATMENT
☐ CAUSAL RELATIONSHIP TO INJURY
☐ FURTHER TREATMENT NEEDED?
☐ APPORTIONMENT (WC ONLY)
☐ REVIEW JOB DESCRIPTION
☐ ARE THERE ANY PRE-EXISTING AND SUSEQUENT INJURIES

☐ PERMANENCY / SCHEDULE LOSS OF USE
☐ HAS CLAIMANT REACHED MAXIMUM MEDICAL IMPROVEMENT? (WC ONLY)
☐ HAS MEDICAL ENDPOINT BEEN REACHED/PREACCIDENT STATUS? (NF ONLY)
☐ CAN CLAIMANT RETURN TO WORK AT THIS TIME? IF NOT, WHY?
☐ WORK RESTRICTIONS/LIGHT DUTY
☐ M & S (Section 15-8 NY WC)
☐ PERMANENCY SPINE (2012 NEW YORK WORKERS COMPENSATION)

COMMENTS: _____

TYPE OF CLAIM ☐ GL ☐ DB ☐ NF ☐ WC ☐ BI ☐ OTHER _____

DATE THE MEDICAL REPORT IS NEEDED: _____
COPY FILE REVIEW: ☐ INSURANCE CO. ☐ ALL PARTIES
COPY REPORT TO: ☐ ATTORNEY ☐ ATTENDING MD
OTHER: _____

Office Use Only

PHYSICIAN: _____
DR. REQUESTED: _____
DATE/TIME OF EXAM: _____/_____ am pm