

REFERRAL FORM

(800) 807-5831
(716) 626-4213
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First Choice EVALUATIONS

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

ADJUSTER INFORMATION

DATE OF REQUEST: _____ CLAIM #: _____ RE-EXAMINATION:
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 RECEIPT 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 IIME
- DIAGNOSIS/PROGNOSIS PERMANENCY / SCHEDULE LOSS OF USE (OF EXTREMITIES)
- DEGREE OF DISABILITY
 - If Attending Physician gave SLU opinion **prior** to 1/1/18, use the 2012 New York Workers Compensation Guidelines.
 - If Attending Physician gave SLU opinion **after** 1/1/18, use the 2018 New York Workers Compensation Guidelines.
 - 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
 - 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 GUIDELINES)

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