EVOnational IME Referral Form

Phone: 301-644-2150
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Email referrals: referrals@evonational.com

Referrer Name		**Date**	
Company Name		**Additional Parties to CC**	

Claimant Name		**SSN**				**DOB**	
Address						**Apt. or Unit #**	
City, State		**Zip Code**		**Phone**		**Alt. Phone**	

Claimant Attorney	**Attorney's Address**	**Phone/ Fax/ Email**
		Phone: **Fax:** **Email:**

Hearing Date	**Date(s) of Injury**	**Claim #**		**Type of Claim (WC, PIP, BI, Other)**
				WC
Injured Body Part(s)		**State of Jurisdiction**	**Insured/ Employer**	**Treating Doctor**
Transportation	◯ Yes ◯ No	**Interpretation**	◯ Yes ◯ No **If yes, language desired:**	
Specialty Requested (i.e. ENT, Orthopedic, Neurology, etc.)			**Physician Requested (optional)**	

Questions for Cover Letter:

☐ Detailed history, diagnosis and prognosis.	☐ Please address causal relationship. Are the claimant's current complaints causally related to the date of accident?
☐ Has the treatment received been reasonable, necessary and causally related to the accident date?	☐ Please address the claimant's work capabilities. Is the claimant able to work full or light duty at this time? Please specify any work restrictions you feel are necessary and indicate how long these restrictions should remain in place.
☐ Has the claimant reached Maximum Medical Improvement (MMI). If not, when do you anticipate MMI?	☐ If at MMI, please provide a Permanent Impairment Rating according to the AMA Guidelines. Please apportion your rating to include any pre-existing and/or unrelated conditions.
☐ Do you have any further medical treatment recommendations for this claimant? If so, please elaborate on the specific treatment and durations of the treatment plan.	☐ Please address and list any preexisting conditions.

Brief description of injury and/or additional questions for cover letter:

SEND REFERRAL

Or please save and email to :
referrals@evonational.com