



HEALTH CLAIM RESOURCES

Referral Form

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www.healthclaimresources.com
info@healthclaimresources.com

Referror: _____ Date: _____
Company: _____ Fax: () _____
Address: _____
City/State/Zip: _____ Phone: () _____
E-mail: _____ Hearing Date: _____

Claimant: _____ Phone: () _____
Address: _____
Date of Birth: _____ City/State/Zip: _____
S.S.#: _____

CLAIMANT DATA

Insured: _____
Claim No.: _____
Type: W/C _____ BI _____ Other _____
D.O.I. _____
Injury: _____
Job Description: _____
Treating Doctor: _____

CLAIMANT ATTORNEY

Attorney: _____
Law Firm: _____
Address: _____
City/State/Zip: _____
Phone: () _____

EXAM TYPE

- | | |
|---|--|
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Dentristy | <input type="checkbox"/> Plastic Surgery |
| <input type="checkbox"/> Dermatology | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Ear, Nose & Throat | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Internal Medicine/Cardiology | <input type="checkbox"/> FCE |
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ophthalmology | _____ |
| <input type="checkbox"/> Oral Surgery | |

Questions or Instructions to be Addressed:

- Permanent Impairment/Loss of Function
- Permanent Scarring
- Causal Relationship
- History, Diagnosis, Prognosis
- End Results/Maximum Medical Improvement
- Length of Disability
- Work Capacity (Full Duty or Light Duty)
- Medical Treatment Recommendations

**Please include a list of any other specific questions to be answered in cover letter for HCR use.*

FOR HCR USE ONLY

Date: _____ Time: _____ Doctor: _____