PDC
PSYCHIATRIC IME / PEER REVIEW Referral Form

Referral Source:_____ Company Name: _____

Phone & Extension: _____ Fax #:_____

Date of Referral: _____ Date Needed: _____

Please ✔all that apply: ☐ **IME** ☐ **Peer Review**

☐ Psychiatrist
☐ Psychologist (e.g. depression, personality, IQ)
☐ Neuropsychologist (e.g. cognitive functioning, motor skills)
☐ Other

_____
(please specify other specialty)

Case Details *(Please complete all sections and type or print clearly)*

Name of Insured: _____ Date of Disability:_____

Street/City/State/Zip: _____

Phone Number: _____ Date of Birth:_____

Policy #: _____ Occupation: _____

Reported Impairments and / or Diagnoses:_____

_____

Present/Past Treatment Providers	**Name**	**Specialty**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Previous IME Providers & specialty *(if known):*_____ _____

Attorney representing Insured: _____

Amount of Records to be Reviewed (# inches): _____ _____ Videotape: ___ Yes____No

Brief summary of case: _____

_____

_____

_____

_____

_____

_____

_____

_____

Other Requests:_____

_____

_____

A PDC IME Coordinator will contact you within 2 business days to confirm receipt of referral and discuss request and costs.

Fax page to: IME Coordinator (413) 747-9376
Call PDC at (800) 463-0095 with any questions
PDC 1350 Main Street – STE 1600, Springfield, MA 01103-1641
E-mail: PDC@pdcnetwork.com