PDC
MEDICAL IME, FCE, PEER REVIEW Referral Form

Referral Source:_____ Company Name:_____

Phone & Extension: _____ Fax #_____

Date of Referral: _____ Date Needed: _____

Please check all that apply: ☐ **IME** ☐ **Peer Review** ☐ **FCE**

☐ Orthopedic Surgeon/Orthopedist ☐ Physical Medicine & Rehabilitation (Physiatrist)
☐ Internal Medicine ☐ Occupational Medicine Physician ☐ Neurologist ☐ Neurosurgeon
☐ Cardiologist ☐ Rheumatologist ☐ Physical Therapist / Occupational Therapist
☐ 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**
Include physical therapists, etc. If necessary, use a separate sheet to identify all treatment providers.	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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

Attorney representing insured: _____

Amount of Records to be Reviewed (# inches): _____Videotape:____Yes ___ No

Brief summary of case: _____

_____

_____

_____

_____

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_____

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