

RKI CLAIMS SPECIALISTS LLC DIAGNOSTIC REFERRAL FORM
PHONE: 866-364-8567 FAX: 866-364-8570 EMAIL: REFERRALS@RKICLAIMS.COM

Adjuster's Name:		Company:	
Email:	Phone:	Fax:	

Patient's Name:		Date of Birth:	
Address:		Social Security #:	
		Nature of Injury:	
Phone:		Date of Injury:	
Cell #:		Claim Number:	
Patient's Attorney:		Phone:	Fax:

Prescribing Doctor:	Phone:
Practice:	Fax:

Exam Needed By:	Contrast Needed: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> BONE SCAN <input type="checkbox"/> X-RAYS <input type="checkbox"/> EMG <input type="checkbox"/> FCE <input type="checkbox"/> OTHER	
<input type="checkbox"/> Lumbar <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic Shoulder <input type="checkbox"/> R <input type="checkbox"/> L Knee <input type="checkbox"/> R <input type="checkbox"/> L Other <input type="checkbox"/>	
Diagnosis or Rule Out:	