

RKI CLAIMS SPECIALISTS LLC IME REFERRAL FORM

PHONE: 866-364-8567 FAX: 866-364-8570 EMAIL: REFERRALS@RKICLAIMS.COM

Adjuster's Name:	Company:	
Email:	Phone:	Fax:
Defense Atty/Nurse Case Mgr:	Company:	
Email:	Phone:	Fax:

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

Doctor Requested:	Transportation: YES <input type="checkbox"/> NO <input type="checkbox"/>	
Orthopedic <input type="checkbox"/>	Neurosurgeon <input type="checkbox"/>	Translator: YES NO Language:
Psych <input type="checkbox"/>	Neurologist <input type="checkbox"/>	<b style="color: red; text-decoration: underline;">HEARING DATE: _____

COVERLETTER WILL BE PROVIDED BY:

RKI DEFENSE ATTORNEY NURSE CASE MANAGER SELF

- DIAGNOSIS, PROGNOSIS, HISTORY
- CAUSAL/ PRE-EXISTING CONDITION
- RETURN TO WORK/ RESTRICTIONS
- NEED FOR FUTURE TREATMENT
- NEED FOR SURGERY
- MAXIMUM MEDICAL IMPROVEMENT, IF NOT WHEN
- PPD RATING
- APPORTIONMENT
- OTHER