REQUISITION FOR INDEPENDENT EXAMINATION

CompreMed BY NEUPATH
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Toll-free. 1-888-777-2500
www.CompreMed.com
Referrals to: info@compremed.com or Fax. 1-888-538-2501

PLEASE CONTACT US IF YOU REQUIRE INSTRUCTIONS REGARDING THE REFERRAL PROCEDURE

- A release of information naming all parties to receive any information relating to this referral must be signed by the claimant / employee prior to commencement
- Should you cancel this request, an administration and/or Provider cancellation fee may apply.

(1) INSURER / EMPLOYER INFORMATION

COMPANY NAME | WSIB Claim? ☐ Yes ☐ No

ADDRESS

CITY / TOWN | PROV | POSTAL CODE

CONTACT NAME

CONTACT PHONE | CONTACT FAX

POLICY # / CASE NUMBER OR WSIB CLAIM | INSURER / EMPLOYER FILE #

(2) REFERRING AGENCY INFORMATION (If Applicable)

REFERRING AGENCY NAME

ADDRESS

CITY / TOWN | PROV | POSTAL CODE

CONTACT NAME

CONTACT PHONE | CONTACT FAX

OTHER INFORMATION

Any **REPORTS** relating to this referral should be sent to: (Please check the applicable boxes below -If Other, please give Name and Address)

(3a) ☐ Insurer / Emp. ☐ Referring Agency ☐ Other:

The **INVOICE** for this referral should be sent to: (Please check **ONLY ONE** of the boxes below -If Other, please give Name and Address)

(3b) ☐ Insurer / Emp. ☐ Referring Agency ☐ Other:

(4) CLAIMANT / EMPLOYEE INFORMATION

FIRST NAME | LAST NAME | SEX ☐ M ☐ F

ADDRESS

CITY / TOWN | PROV | POSTAL CODE

HOME PHONE | BUSINESS PHONE

DATE OF BIRTH (M/D/Y) | OCCUPATION

EMPLOYER'S NAME (if different than (1) above) | PHONE

DATE OF LOSS | CAUSE OF LOSS

PRIOR & CURRENT TREATING PHYSICIANS (list ALL!)

Name	Phone

(5) DETAILS OF IME, IPE OR FAE

☐ **MEDICAL SPECIALTY:** Please select specialty

☐ **FUNCTIONAL ASSESSMENT**

- ☐ WORKSITE ANALYSIS
- ☐ TRANSFERABLE SKILLS ANALYSIS
- ☐ HOME ASSESSMENT

☐ FAE / FCE ☐ **ANY** ☐ **OWN** (PDA or Job desc. required)

1day ☐ 2 day ☐

DIAGNOSIS: _____

COMMENTS:

TRANSLATOR REQUIRED: _____

TRAVEL REQUIREMENTS / RESTRICTIONS: _____

DATES CLAIMANT NOT AVAILABLE: _____

(**Please forward a seperate sheet with questions to be addressed**)

(6)

REQUEST TO PROCEED WITH INDEPENDENT MEDICAL EXAMINATION

I hereby declare that I am authorized to request this Independent Examination on behalf of the insurer / employer described in section 1 of this form. I further declare that I have received the appropriate authorization from the claimant / employee (named above in section 4) to release any and all information related to this assessment to CompreMed Canada Inc. and its agents for the purpose of performing this assessment and delivering the assessment report.

SIGNATURE | *PRINT NAME* | *DATE*

DO NOT WRITE BELOW THIS LINE