OrthoCarolina

WORKERS' COMPENSATION SPECIAL EXAM INFORMATION FORM – FAX: 704-945-7684

○ IME : This is an Independent Medical Evaluation

○ CSO: This is a Comprehensive Second Opinion

On the above, there will be no diagnostic tests performed unless the MD requires them to complete his/her evaluation.

These are one-time evaluations only.

○ CSO WITH TRANSFER OF CARE (The requesting party authorizes total and complete transfer of care.)

All evaluations consist of review of all medical records, x-rays, and any other diagnostic studies.

PATIENT INFORMATION:

NAME: _____ DOB: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ E-MAIL: _____

EMPLOYER INFORMATION:

NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

BILLING INFORMATION:

PARTY SCHEDULING: _____ PHONE: _____ FAX: _____

SCHEDULING PARTY'S E-MAIL: _____

REPORT/BILL TO: _____

ADJUSTER: _____PHONE: _____ FAX: _____

ADJUSTER'S E-MAIL: _____

CARRIER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

JURISDICTION: _____ CLAIM NO. _____ DATE OF INJRY: _____

BODY PART(S) TO BE EVALUATED: _____

ADJUSTER/ATTORNEY/NURSE CASE MANAGER/AUTHORIZED PARTY : _____

DATE: _____

ORTHOCAROLINA USE ONLY

TODAY'S DATE: _____OCN: _____ OC PHYSICIAN: _____

APPT. DAY: _____DATE: _____ TIME: _____ MD: _____LOCATION: _____

DATE APPT. CANCELLED: _____ REASON: _____

DATE APPT. RESCHEDULED: _____

INVOICE SENT ON: _____ PAYMENT RECEIVED ON: _____ CHECK NO.: _____