Vocational Services Referral Form

**▶ SERVICE/S REQUESTED**

|  |  |
| --- | --- |
| **[ ]  Vocational Case Management** | **[ ]  Expert Rehabilitation Consultant** |
| **[ ]  Vocational Evaluation Services**  | **[ ]  Vocational Guidance and Career Counseling** |
| **[ ]  Vocational Expert**  | **[ ]  Labor Market Survey** |
| **[ ]  Employability Analysis** | **[ ]  Job Search & Placement** |
| **[ ]  Transferable Skills Analysis** | **[ ]  Other (specify):**       |

**▶ REFERRAL SOURCE/INSURANCE INFORMATION**

**Company Name:**       **Adjuster Name:**

**Street Address:**       **Phone:**

**City, State & Zip:**       **Fax:**

**Claim Number:**       **Date of Referral** *(m/d/yyyy)***:**

**▶ EMPLOYER**

**Employer Name:**       **Contact Person:**

**Street Address:**

**City, State & Zip:**

**Phone:**       **Fax:**

**▶ CLAIMANT INFORMATION**

**Name:**       **Date of Injury** *(m/d/yyyy)***:**

**Street Address:**

**City, State & Zip:**

**Phone:**       **Weekly Wage: $**

**Date of Birth** *(m/d/yyyy)***:**       **Job Assignment at Time of Injury:**

**SSN:**

**Accident Details:**

**▶ MEDICAL INFORMATION**

**Primary Physician Name:**

**Street Address:**       **Phone:**

**City, State & Zip:**       **Fax:**

**Diagnosis:**

**Current Work Status:**

**Date of Next Office Visit** *(m/d/yyyy)***:**

**▶ LEGAL INFORMATION**

**IW Attorney:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**      **Defense Attorney:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**

**▶ COMMENTS:**

***By typing my name below I am authorized to make this referral on behalf of the Carrier and agree to the pricing of the Billing Guidelines and the Referral Terms and Conditions as published*** [***HERE***](http://www.old.ekhealth.com/component/content/article/432)***.***

 **NAME:       DATE:**