

**Date:** Click or tap to enter a date.

|  |  |  |
| --- | --- | --- |
| **IME/CME:** [ ]  | **PEER/RECORD REVIEW:** [ ]  | **DIAGNOSTIC/RADIOLOGY REVIEW:** [ ]  |

 **CARRIER/ATTORNEY INFO:**

**Company:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Attorney/Adjuster:** Click or tap here to enter text.

**Phone Number:** Click or tap here to enter text.

**Email Address:** Click or tap here to enter text.

**CLAIM INFO:**

**Claimant Name:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Phone Number:** Click or tap here to enter text.

**Email Address:** Click or tap here to enter text.

**Date of Birth:** Click or tap to enter a date.

**Social Security Number:** Click or tap here to enter text.

**Date of Accident:** Click or tap to enter a date.

**Claim #:** Click or tap here to enter text.

**Claimant Attorney:** Click or tap here to enter text.

**Attorney Address:** Click or tap here to enter text.

**Attorney Phone Number:** Click or tap here to enter text.

**Attorney Fax Number:** Click or tap here to enter text.

**Attorney Email:** Click or tap here to enter text.

**CASE TYPE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PIP:** [ ]  | **BI:** [ ]  | **UM:** [ ]  | **Slip & Fall:** [ ]  | **Work Comp:** [ ]  | **Other:**  |

**SPECIALTY REQUESTED:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Orthopedist** [ ]  | **Chiropractor** [ ]  | **Neurologist** [ ]  | **Neurosurgeon** [ ]  | **Other:**Click or tap here to enter text. |
| **Psychiatrist (MD)** [ ]  | **Psychologist (PhD)** [ ]  | **Internist** [ ]  | **Physiatrist (PMR)** [ ]  |  |
| **Osteopath (DO)** [ ]  | **Radiologist** [ ]  | **Dental** [ ]  | **Pain Management** [ ]  |  |

*…please continue onto page 2…*

****

**TREATING PHYSICIAN INFO:**

**Physician Name:** Click or tap here to enter text.

**Physician Address:** Click or tap here to enter text.

**Physician Phone Number:** Click or tap here to enter text.

**AREA OF CONCERN:**

|  |  |  |
| --- | --- | --- |
| **MMI:** [ ]  | **Need for Further Treatment:** [ ]  | **Degree of Disability:** [ ]  |
| **Causal Relationship:** [ ]  | **Need for Surgery:** [ ]  | **Permanency:** [ ]  |
| **Ability to Return to Work:** [ ]  | **Activity Restrictions, if any:** [ ]  | **Other:**Click or tap here to enter text. |

**SPECIAL INSTRUCTIONS:**

Click or tap here to enter text.

**Please email this referral as well as your medical records to us at:**

**peg@pegime.com** **or** **records@pegime.com**