

Referral Checklist for 3D Motionprint® Evaluation Services

In order to provide our clients with the highest quality results, we would request the following information as appropriate and applicable for all referrals.

INJURED WORKER/PATIENT INFORMATION

- Complete name, address & contact information
- DOB & SSN
- DOI, IW & Supervisor's description of injury and FROI
- Occupation; Job Description with essential physical strength and postural demands any specific job task requirements

CLAIMS ADJUSTER

- Complete name, address (billing) & contact information – fax and email address
- Claim number
- Is this evaluation for OWN occupation or ANY occupation?
- Provide any specific questions to be addressed by evaluation

CASE MANAGER

- Complete name, address (billing) & contact information – fax and email address
- Case Number
- Is this evaluation for OWN occupation or ANY occupation?
- Provide any specific questions to be addressed by evaluation

PHYSICIAN

- Complete name, office address & contact information – fax and email address
- Provide a copy of your practice patient demographics sheet & script
- ICD-9 (s)
- Relevant medical records – previous injuries, accidents, diagnostic reports, operative notes, list of medications & dosages, number of PT sessions, dates/responses to any procedures
- Initial diagnosis, physician evaluation and most recent clinic notes
- Impairment Rating Analysis – AMA 5th Edition
- Impairment Rating Analysis – AMA 6th Edition – Required for Federal employees