

Garger Associates, LLP ♦ Garger C. Associates, LLP
Providing IME Services Since 1985

TODAY'S DATE: _____ **MEDICAL SPECIALTY REQUESTED:** _____

NAME: _____	PHONE: _____
COMPANY: _____	ADDRESS: _____

REQUESTED SERVICE

- EXAMINATION RE-EXAMINATION (DATE OF LAST EXAM : _____)
- ADDENDUM RECORD REVIEW PEER REVIEW

TYPE OF CLAIM

- WORKERS COMP NO FAULT DISABILITY GENERAL LIABILITY AUTO LIABILITY FITNESS FOR DUTY

PATIENT INFORMATION

NAME: _____	PHONE: _____		
ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____
DATE OF BIRTH: _____	SOCIAL SECURITY # _____		
DATE OF INJURY: _____	BODY PART: _____		
CLAIM NUMBER: _____	WCB# _____		
EMPLOYER/INSURED: _____			
TREATING PHYSICIAN: _____			
ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____
PATIENT'S ATTORNEY: _____			
ADDRESS: _____	CITY: _____	STATE: _____	ZIP CODE: _____

BRIEF HISTORY: _____

CONTROVERTED CASE: YES NO

PLEASE INDICATE WHICH QUESTIONS YOU WOULD LIKE THE DOCTOR TO ADDRESS:

- I will have a detailed cover letter indicating questions I would like the doctor to address (no need to check boxes below)
- Diagnosis Prognosis Causal Relationship Degree of Disability
- Light Duty Restrictions Permanency Treatment Recommendations Need for Surgery
- Apportionment* 15-8 Application* *Prior medical records must be included to address these questions

OTHER/SPECIAL INSTRUCTIONS:

IME SCHEDULED

DATE: _____ **TIME:** _____ **DOCTOR:** _____ **LOCATION:** _____

Records Rcv'd _____ IME-5 Mailed: _____