6400 Millcreek Drive Unit 9, Mississauga, ON, L5N 3E7
Toll-free. 1-888-777-2500
www.neupath/compremed.com
Referrals to: info@compremed.com or Fax. 1-888-538-2501

REQUISITION FOR INDEPENDENT EXAMINATION

PLEASE CONTACT US IF YOU REQUIRE INSTRUCTIONS REGARDING THE REFERRAL PROCEDURE

- A release of information naming all parties to receive any information relating to this referral must be signed by the claimant / employee prior to commencement
- Should you cancel this request, an administration and/or Provider cancellation fee may apply.

(1) INSURER / EMPLOYER INFORMATION

COMPANY NAME		WSIB Claim? ☐ Yes ☐ No
ADDRESS		
CITY / TOWN	PROV	POSTAL CODE
CONTACT NAME		
CONTACT PHONE	CONTACT FAX	
POLICY # / CASE NUMBER OR WSIB CLAIM	INSURER / EMPLOYER FILE #	

(2) REFERRING AGENCY INFORMATION (If Applicable)

REFERRING AGENCY NAME		
ADDRESS		
CITY / TOWN	PROV	POSTAL CODE
CONTACT NAME		
CONTACT PHONE	CONTACT FAX	
OTHER INFORMATION		

Any **REPORTS** relating to this referral should be sent to: (Please check the applicable boxes below -If Other, please give Name and Address)

(3a) ☐ Insurer / Emp. ☐ Referring Agency ☐ Other:

The **INVOICE** for this referral should be sent to: (Please check **ONLY ONE** of the boxes below -If Other, please give Name and Address)

(3b) ☐ Insurer / Emp. ☐ Referring Agency ☐ Other:

(4) CLAIMANT / EMPLOYEE INFORMATION

FIRST NAME	LAST NAME	SEX ☐ M ☐ F
ADDRESS		
CITY / TOWN	PROV	POSTAL CODE
HOME PHONE	BUSINESS PHONE	
DATE OF BIRTH (M/D/Y)	OCCUPATION	
EMPLOYER'S NAME (if different than (1) above)	PHONE	
DATE OF LOSS	CAUSE OF LOSS	

PRIOR & CURRENT TREATING PHYSICIANS (list ALL!)

Name	Phone

(5) DETAILS OF IME, IPE OR FAE

☐ **MEDICAL SPECIALTY:** ____________________

☐ **FUNCTIONAL ASSESSMENT**

- ☐ WORKSITE ANALYSIS
- ☐ TRANSFERABLE SKILLS ANALYSIS
- ☐ HOME ASSESSMENT
- ☐ FAE / FCE ☐ **ANY** ☐ **OWN** (PDA or Job desc. required)

DIAGNOSIS: ____________________

COMMENTS:

TRANSLATOR REQUIRED: ____________________

TRAVEL REQUIREMENTS / RESTRICTIONS: ____________________

DATES CLAIMANT NOT AVAILABLE: ____________________

(**Please forward a seperate sheet with questions to be addressed**)

(6) REQUEST TO PROCEED WITH INDEPENDENT MEDICAL EXAMINATION

I hereby declare that I am authorized to request this Independent Examination on behalf of the insurer / employer described in section 1 of this form. I further declare that I have received the appropriate authorization from the claimant / employee (named above in section 4) to release any and all information related to this assessment to CompreMed Canada Inc. and its agents for the purpose of performing this assessment and delivering the assessment report.

SIGNATURE	*PRINT NAME*	*DATE*

DO NOT WRITE BELOW THIS LINE