****

ERGONOMICS REFERRAL FORM

**▶ REFERRAL DETAILS**

**Employee Name:**

**DOB:**       **Phone:**

**Job Title:**       **Work Phone:**       **Work Email:**

**Work Street Address:**       **City, State & Zip:**

**Claim #:**       **DOI:**

 ***Can we schedule directly with the Employee?***

**Yes [ ]  No [ ]  …***If No, then who should we contact?***Name:**

 **Email:**       **Phone:**

**▶ CARRIER / REFERRAL SOURCE**

**Company Name:**

**Adjuster Name:**       **Phone:**       **Email:**

**Street Address:**       **City, State & Zip:**

**▶ EMPLOYER**

**Employer Name:**

**Employer Contact Name:**       **Phone #:**       **Email:**

**▶ REPORTS SENT TO:**

**1) Name:**       **Email:**

**2) Name:**       **Email:**

**▶ BILL SENT TO:**

**Name:**

**Phone:**       **Email:**

**▶ employee’s Symptom/s at this time:**

**▶ ATTORNEYS**

**Applicant AAL:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**

**Defense AAL:**

**Phone:**       **Fax:**

**Street Address:**

**City, State & Zip:**

**▶ SERVICES REQUESTED**

|  |  |
| --- | --- |
| **[ ]  Ergonomic Evaluation – *Level 1*** | **[ ]  Training Class – *Office Ergonomics*** |
| **[ ]  Ergonomic Evaluation – *Level 2*** | **[ ]  Training Class – *Back Lifting Safety*** |
| **[ ]  Ergonomic Evaluation – *Level 3*** | **[ ]  Training Class – *Stretching for Prevention*** |
| **[ ]  Ergonomic Evaluation – *Level 4*** | **[ ]  Training Class – *Other*:**       |
| **[ ]  Job Analysis** |  |

***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:**