IME/EME and SMO Appointments

Patient Information

Patient Name _____

Address _____

City, State, Zip _____

Phone Number _____ Cell Phone _____

Date of Birth _____ SSN _____

Claim Number _____

Injury Information

What will Dr. Gandy examine? _____Date of Injury_____

Does Dr. Gandy need to address causation at this evaluation? _____ Yes _____No

Will specific questions be sent for Dr. Gandy to answer in the report? _____ Yes _____No
(If Yes, please make sure questions accompany the records or get emailed to Janine)

Contact Information

Person Completing This Form_____

Name of Company _____

Phone _____ Fax _____

Who is Responsible for Payment?_____

List Name and Fax Number of Those Who May Receive a Copy of the IME_____

_____

**** PLEASE NOTE IF CAUSATION IS ASKED, THE EXAM IS CONSIDERED AN IME/EME**

EXAMINATION	CHECK ONE
IME or EME- 4th, 5th,6th Edition	
SMO	
Impairment Rating Only- 4th or 5th	
Impairment Rating Only - 6th	

Upon completion of this form, please email to jmorgan@medlegalconsultation.com for an appointment to be scheduled.

****** NOTE: DO NOT SEND RECORDS BY EMAIL. THEY MUST BE MAILED OR HAND DELIVERED *******

FOR OFFICE USE ONLY

Appointment _____ Pre-Pay Letter sent? _____

Scheduled by _____ Fee _____