

Surgery or Diagnostic Testing Request

(Excludes Physical Medical Requests)

Date: _____ Claim #: _____ DOI: _____ DOB: _____

Injured Worker's name: _____

Name of physician recommending procedure: _____

Name of contact person: _____

Email of Contact Person: _____

Office phone: _____ Fax: _____

List injured/treated body part, right/left/bilateral:

Surgery recommended: _____

Facility name: _____

Patient has been counseled on the effects of nicotine: Yes No

Is any post-operative durable medical equipment needed: Yes No

If yes, list all post-operative durable medical equipment:

Diagnostic test recommended:

Facility name: _____

Injections recommended:

Number of Injections: _____ Frequency of Injections: _____

Other treatment recommendations:

Facility Name: _____