CIS onsite
Comprehensive Industrial Services, Inc.

REFERRAL FORM – Case Management **DATE:** _____

Referred by: _____ Title _____
Company: _____ Ph #: _____ Fax #: _____
Address: _____ City: _____ State: _____ Zip: _____

EMPLOYEE / CLAIMANT INFORMATION

Name: _____ Ph#: _____ Cell#: _____
Email: _____ OK to text: Y_____ N _____
Address: _____ City: _____ State: _____ Zip: _____
Claim#: _____ SS#: _____ DOB: _____
Occupation: _____ Hours/ Shift: _____ Weekly Wage: $ _____
Primary Diagnosis: _____ ICD-9: _____ DOL: _____
Secondary Diagnosis: _____ ICD-9: _____ DOL: _____
Type of Coverage: _____ WC _____ LTD _____ Group Health ____ Self-Insured ____ Other: _____

EMPLOYER INFORMATION

Name: _____ Ph#: _____ Fax #: _____
Address: _____ City: _____ State:_____ Zip: _____
Contact: _____ Title: _____

INSURANCE / BILLING INFORMATION

Name: _____ Ph#: _____ Fax #: _____
Address: _____ City: _____ State:_____ Zip: _____
Contact: _____ Title: _____

PHYSICIAN INFORMATION

Name: _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone#: _____ Fax#: _____

ATTORNEY INFORMATION

Plaintiff

Name: _____
Address: _____
City: _____ St: _____ Zip: _____
Phone#: _____Fax#: _____

Defense

Name: _____
Address: _____
City: _____ St: _____ Zip: _____
Phone#: _____Fax#: _____

SERVICES REQUESTED

_____ Medical Case Management
_____ Vocational Case Management
____ Vocational Assessment
_____ Vocational Placement
_____ Labor Market Analysis
____ Expert Testimony
_____ Job Analysis
_____ Ergonomic Analysis
_____ Other (Please Specify) _____

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