



WORKERS COMPENSATION INFORMATION

THE SPORTS MEDICINE
INSTITUTE OF INDIANA

PATIENT _____ Appt Date _____ Dr. _____

Address _____ Phone _____

_____ dob _____

DOI _____ Claim# _____

Injury/Complaint _____

Exam Type: Take over care Consult only IME Work Eval Other _____

EMPLOYER _____ **Contact** _____

Address _____ Fax _____

_____ Phone _____

WC INSURANCE _____ **Adjustor** _____

Address _____ Fax _____

(Claims) _____ Phone _____

Mailing address _____

CASE MGMT CO _____ **Case Mgr** _____

Address _____ Fax _____

_____ Phone _____

REFERRING SOURCE (Doctor) _____

(Company) _____

Address _____ Fax _____

_____ Phone _____

Comments: _____
