



## Special Exam Application Form

Complete all fields. Incomplete forms will be returned.

### Exam Type

Independent Medical Examination (IME)    Consultation Without Transfer    Consultation With Transfer

### Patient Information

<b>Patient Name:</b>		<b>Date of Birth:</b>	
<b>Preferred Language:</b>		<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Mailing Address:</b>			
<b>Email Address:</b>		<b>Phone #:</b>	
<b>Social Security #:</b>		<b>Date of Injury:</b>	
<b>Injured Body Part:</b>	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral	<b>Occupation:</b>	

### Employer Information

<b>Employer:</b>		<b>Phone #:</b>	
<b>Employer Address:</b>			

### Prior Treatment

<b>Has this patient received treatment? <i>If yes, indicate where (records must be provided)</i></b>	
<b>Has surgery occurred for this injury?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Imaging on file:</b> <input type="checkbox"/> X-rays <input type="checkbox"/> CT <input type="checkbox"/> MRI

### Case Manager / Insurance Information

<b>Case Manager:</b>	<input type="checkbox"/> Telephonic <input type="checkbox"/> Field	<b>Phone #:</b>	
<b>Email:</b>		<b>Fax #:</b>	
<b>WC Insurance Carrier:</b>		<b>WC Claim #:</b>	
<b>Billing Address:</b>		<b>Jurisdiction:</b>	
<b>Bill Review Company:</b>		<b>Telephone/Email:</b>	
<b>Adjuster Name:</b>		<b>Email:</b>	
<b>Phone #:</b>		<b>Fax #:</b>	

### Preferred Practitioner / Location

<b>Practitioner:</b>		<b>Location:</b>	<input type="checkbox"/> Clinton Township <input type="checkbox"/> Lenox
----------------------	--	------------------	--

## Services Requested

Consultation  Treatment  Labs  X-ray  EMG/NCS  CT  MRI  Physical Therapy

**Please check who is signing below:**  Adjuster  Nurse Case Manager  Employer

---

Signature

Printed Name / Title

Date

---

Movement Orthopedics, PLLC | 43475 Dalcoma Dr., Suite 250, Clinton Township, MI 48038 | (586) 436-3785 | [www.movementortho.com](http://www.movementortho.com)