

REFERRAL FORM

| | | |
|----------------|-----------|-------------------------------|
| Referral Date: | Due Date: | <input type="checkbox"/> RUSH |
|----------------|-----------|-------------------------------|

SERVICES REQUESTED

| | | | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--|--|------------------------------------|------------------------------|----------------------------------|
| <input type="checkbox"/> Sub Rosa | <input type="checkbox"/> AOE/COE* | <input type="checkbox"/> Liability | <input type="checkbox"/> Auto Theft Inv. | <input type="checkbox"/> Recorded Statements | <input type="checkbox"/> SIU Fraud | <input type="checkbox"/> DMI | <input type="checkbox"/> Other** |
|-----------------------------------|-----------------------------------|------------------------------------|--|--|------------------------------------|------------------------------|----------------------------------|

***AOE/COE Interview:** Please check all that apply

- | | | |
|------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Claimant | <input type="checkbox"/> Medical Authorization | <input type="checkbox"/> WCAB Search |
| <input type="checkbox"/> Employer | <input type="checkbox"/> Medical Records | <input type="checkbox"/> Other |
| <input type="checkbox"/> Witnesses | <input type="checkbox"/> Personnel Records | |

Background: Please check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Bankruptcy | <input type="checkbox"/> Skip Trace |
| <input type="checkbox"/> Civil Search | <input type="checkbox"/> WCAB Search |
| <input type="checkbox"/> Criminal Search | <input type="checkbox"/> Police Report |

****Other:** _____

CLIENT INFORMATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|------------------|--|----------|--|----------|--|-------------------|--|--------|--|----------------|--|--|----------------|--|-------------------|--|--------------------------|--|------------------|--|------------------------|--|----------|--|-------------------|--|------------------|--|
| <table style="width:100%;"> <tr><td>Claim Number:</td><td></td></tr> <tr><td>Claims Examiner:</td><td></td></tr> <tr><td>Company:</td><td></td></tr> <tr><td>Address:</td><td></td></tr> <tr><td>City / St. / Zip:</td><td></td></tr> <tr><td>Phone:</td><td></td></tr> <tr><td>Email Address:</td><td></td></tr> </table> | Claim Number: | | Claims Examiner: | | Company: | | Address: | | City / St. / Zip: | | Phone: | | Email Address: | | <table style="width:100%;"> <tr><td>Employer Name:</td><td></td></tr> <tr><td>Employer Address:</td><td></td></tr> <tr><td>Employer Contact/ Phone:</td><td></td></tr> <tr><td>Defense Counsel:</td><td></td></tr> <tr><td>Attorney Name & Phone:</td><td></td></tr> <tr><td>Address:</td><td></td></tr> <tr><td>City / St. / Zip:</td><td></td></tr> <tr><td>Copy to Counsel?</td><td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table> | Employer Name: | | Employer Address: | | Employer Contact/ Phone: | | Defense Counsel: | | Attorney Name & Phone: | | Address: | | City / St. / Zip: | | Copy to Counsel? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Claim Number: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Claims Examiner: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Company: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City / St. / Zip: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Employer Contact/ Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Defense Counsel: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Attorney Name & Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City / St. / Zip: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Copy to Counsel? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

CLAIMANT INFORMATION

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|--|---|---|----------|--|-------------------|--|--------|-------|--------------|--------------------------------|-------------|--|---------|--|---------------|--|--|----------------|--|--------------------|--|--------------------|--|--------------|--|---------|---|------|--|
| <table style="width:100%;"> <tr><td>Claimant:</td><td></td></tr> <tr><td>Address:</td><td></td></tr> <tr><td>City / St. / Zip:</td><td></td></tr> <tr><td>Phone:</td><td>Cell:</td></tr> <tr><td>Description:</td><td>Hgt: Wgt: Hair: Race:</td></tr> <tr><td>Occupation:</td><td></td></tr> <tr><td>Injury:</td><td></td></tr> <tr><td>Restrictions:</td><td></td></tr> </table> | Claimant: | | Address: | | City / St. / Zip: | | Phone: | Cell: | Description: | Hgt: Wgt: Hair: Race: | Occupation: | | Injury: | | Restrictions: | | <table style="width:100%;"> <tr><td>Date of Birth:</td><td></td></tr> <tr><td>Social Security #:</td><td></td></tr> <tr><td>Drivers License #:</td><td></td></tr> <tr><td>Represented:</td><td style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Gender:</td><td style="text-align: right;"><input type="checkbox"/> Male <input type="checkbox"/> Female</td></tr> <tr><td>DOI:</td><td></td></tr> </table> | Date of Birth: | | Social Security #: | | Drivers License #: | | Represented: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Gender: | <input type="checkbox"/> Male <input type="checkbox"/> Female | DOI: | |
| Claimant: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City / St. / Zip: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phone: | Cell: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description: | Hgt: Wgt: Hair: Race: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Occupation: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Injury: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Restrictions: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Social Security #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drivers License #: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Represented: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Gender: | <input type="checkbox"/> Male <input type="checkbox"/> Female | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DOI: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Prior Surveillance Conducted? <input type="checkbox"/> Yes <input type="checkbox"/> No | Deposition Taken? <input type="checkbox"/> Yes <input type="checkbox"/> No | Upcoming Calendar Dates (trial, MSC, etc.)? | | | | | | | | | | | | | | | | | | | | | | | | | | | |

PHYSICIAN INFORMATION Claimant DQME

| | | | | | | | | | | | | | | | |
|---|----------------|--|----------|--|-------------------|--|---|---------|--|--------|--|-------------|--|-------------|--|
| <table style="width:100%;"> <tr><td>Medical Group:</td><td></td></tr> <tr><td>Address:</td><td></td></tr> <tr><td>City / St. / Zip:</td><td></td></tr> </table> | Medical Group: | | Address: | | City / St. / Zip: | | <table style="width:100%;"> <tr><td>Doctor:</td><td></td></tr> <tr><td>Phone:</td><td></td></tr> <tr><td>Appt. Date:</td><td></td></tr> <tr><td>Appt. Time:</td><td></td></tr> </table> | Doctor: | | Phone: | | Appt. Date: | | Appt. Time: | |
| Medical Group: | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | |
| City / St. / Zip: | | | | | | | | | | | | | | | |
| Doctor: | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | | | | |
| Appt. Date: | | | | | | | | | | | | | | | |
| Appt. Time: | | | | | | | | | | | | | | | |

INVESTIGATION INSTRUCTIONS

| | |
|--|--|
| Number of Days: Objectives/Comments: (Please provide any additional information) | |
|--|--|

PLEASE FAX TO: 916-853-2227 or TOLL FREE: 877-782-7672