



**EXCEL**  
MEDICAL CONSULTANTS INC.

### REFERRAL FOR EVALUATION

8300 Fair Oaks Boulevard #404  
Carmichael, CA 95608  
Phone: (916) 944-8368  
Fax: (916) 944-0211

Submit this form by faxing to:  
(916) 944-0211

Date: \_\_\_\_\_

**TYPE OF EVALUATION REQUESTED:**

- AOE/COE – DECISION DUE DATE: \_\_\_\_\_
- DEFENSE QME
- APPLICANT QME
- AME
- IME
- SECOND OPINION CONSULT
- RECORDS REVIEW
- PEER REVIEW

**ADDITIONAL SERVICES:**

TRANSLATION: yes / no \_\_\_\_\_

(What Language?)

TRANSPORTATION: yes / no \_\_\_\_\_

**Medical Records to Be Provided By:**

\_\_\_\_\_

Referred by: \_\_\_\_\_

**ADJUSTER NAME:** \_\_\_\_\_

**INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

Fax#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Applicant Attny:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Applicant Phone #: \_\_\_\_\_

Applicant Fax #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**Defense Attny:** \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Defense Attny Phone#: \_\_\_\_\_

Defense Attny Fax#: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**INJURED WORKER/CLAIMANT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_

Injured Body Part (s): \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Male  Female

Employer Name: \_\_\_\_\_

Claim Number: \_\_\_\_\_

WCAB Case Number: \_\_\_\_\_

Type of Physician: \_\_\_\_\_

Area: \_\_\_\_\_

**FOR OFFICE USE ONLY – REGARDING PHYSICIAN**

Scheduled Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City & State: \_\_\_\_\_

Date & Time: \_\_\_\_\_

Telephone: \_\_\_\_\_

BY COMPLETION OF THIS FORM YOU HAVE AUTHORIZED EXCEL MEDICAL CONSULTANTS TO BILL A REASONABLE LEVEL OF FEES FOR MED-LEGAL EXPENSES PURSUANT TO SECTION 9795 OF THE CALIFORNIA LABOR CODE