SCOTT SIMON, M.S., C.R.C.
15951 LOS GATOS BLVD., STE. 2, LOS GATOS, CA 95032
408-247-0987 FAX 971-9100
SIMONGROUPCONSULTING.COM

Worker's Compensation Referral Form

Referring Attorney: ______________________________________

Referral Type: Le Boeuf ☐ DFEC ☐ Other ☐

Please specify any special requests, upcoming deadlines etc.

____

Applicant's Name:

____

Applicant's Address (please include city, state, zip):

____

____

Employer:

____

DOI:

____

WCAB/EAMS#:

Claim #:

Applicant Attorney's Name:

Address (please include city, state, zip):

Telephone number:

Email Address:

Defense Attorney's Name:

Address (please include city, state, zip):

Telephone number:

Email Address:

Insurance Company Name:

Name of Adjuster:

____

Adjuster's telephone number:

____

Insurance Company Address (please include city, state, zip):

____

____

____

Email Address:

____

MEDICAL RECORDS

Please send chronological organized digital files to our office by your choice of share drive, email to: info@simongroupconsulting.com, or fax to (408) 971–9100

To avoid report delays please send all AME, PQME, QME and PTP reports 30 days prior to the applicant's Vocational Evaluation appointment.

Medical Records: Mailed☐Emailed☐Other☐

*****IMPORTANT***** *Please fill out ALL fields below*
Which medical opinion(s) are we to rely upon for our upcoming report?
Dr.____

Please give a brief overview of medical practitioners involved in the case:
AME Dr._____________________________
Panel QME's / QME

Dr. _________________ Dr. _____________ Dr. ______________

Primary Treating Physician Dr.___________________________
Average Weekly Wage: _____________________________________

ADDITIONAL SERVICES
Interpreter Needed? _________

If so, language:
____

Will your office be setting up interpreter services? _________

Comments:
____

____

____

____