



SERVICE REQUEST FORM – LIFE AND HEALTH INSURERS

Client Name:				Client Title:	
Company Name:					
Company Address:					
Phone:			Fax:		
Email:					
Assistant and/or other Contact Name:				Title:	
Phone:			Fax:		
Email:					
Examine Name: (Mr. Ms.) First:				Last:	
Examinee Address:					
Phone:		Alternate Phone:		Male: <input type="radio"/>	
				Female: <input type="radio"/>	
Date of Birth:		Date of Loss:			
Referring Party/Client File/Certificate/Policy No.:					
Nature of Injury/Diagnosis:					
Interpreter Required:		Yes <input type="radio"/> No <input type="radio"/>		Transportation Required:	
Language:		Yes <input type="radio"/> No <input type="radio"/>		Yes <input type="radio"/> No <input type="radio"/>	
To be booked by Viewpoint		Yes <input type="radio"/> No <input type="radio"/>		To be booked by Viewpoint	
				Yes <input type="radio"/> No <input type="radio"/>	
Viewpoint to Contact Examinee for Scheduling:					
Yes <input type="radio"/> No <input type="radio"/>					

Service(s) Requested:		
<input type="checkbox"/> IME Independent Medical Examination		
<input type="checkbox"/> FCE Functional Capacity Evaluation:	<input type="checkbox"/> One day	<input type="checkbox"/> Two day
<input type="checkbox"/> FAME Functional & Medical Evaluation		
<input type="checkbox"/> IPE Independent Psychiatric Evaluation		
<input type="checkbox"/> CFC Cost of Future Care		
<input type="checkbox"/> CRC Claims Review Committee		
<input type="checkbox"/> JDA Job Demands Analysis		
<input type="checkbox"/> Multidisciplinary Services		
<input type="checkbox"/> Functional Work Evaluation		
<input type="checkbox"/> Return to work - Medical		
<input type="checkbox"/> Executive Summary		
<input type="checkbox"/> Ergonomic Assessment		
<input type="checkbox"/> In-Home Assessment		
<input type="checkbox"/> Neuropsychological Evaluation		
<input type="checkbox"/> Vocational Rehabilitation Evaluation		
<input type="checkbox"/> Document Review		
<input type="checkbox"/> Addendum		
<input type="checkbox"/> Office Meeting/Phone Consultation		
<input type="checkbox"/> Diagnostic Testing		
Consultant Requested:		
Address the following:		
<input type="checkbox"/> Caregiving	<input type="checkbox"/> IRB's	<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Attendant Care	<input type="checkbox"/> Causation	<input type="checkbox"/> Prognosis
<input type="checkbox"/> House Keeping	<input type="checkbox"/> Disability	<input type="checkbox"/> Treatment Recommendation
<input type="checkbox"/> Home Maintenance	<input type="checkbox"/> Impairment	
<input type="checkbox"/> Other	<input type="checkbox"/> Return to work/Workplace Accommodation	
How would you like to receive confirmation of the assessment?		
Email <input type="checkbox"/>		
Fax <input type="checkbox"/>		
Phone <input type="checkbox"/>		

Please also prepare a letter of instruction outlining what issues you wish to be addressed in the report. Should you require any assistance in this area, please contact our offices.

Please fax your request to a central booking office.

VICTORIA
4420 Chatterton Way
Suite 103 V8X 5J2
Ph: 250-881-7885
Fx: 250-881-7870

VANCOUVER
1200 W. 73rd Ave
Suite 606 V6P 6G5
Ph: 604-267-9161
Fx: 604-267-0002

KELOWNA
437 Glenmore Rd.
Suite 203 V1V 1Y5
Ph: 250-860-1887
Fx: 250-860-1359

EDMONTON
11910 – 111 Ave.
Suite 111 T5G 0E5
Ph: 780-453-9047
Fx: 780-455-2035

CALGARY
9250 Macleod Tr. SE
Unit 1 T2J 0P5
Ph: 403-253-4272
Fx: 403-253-7089

NATIONAL TOLL FREE: 1-888-505-0575

www.viewpointmedical.ca