



Paper Forms For Accessing CompreMed Services

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Ask us about our on-line booking system that makes it even easier to book assessments!

Check on the real-time status and progress of your bookings with us any time, send and receive safe and secure messages related to your file, and receive reports on-line in Adobe PDF format.

Review historical bookings and re-print forms.

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REQUISITION FOR INDEPENDENT EXAMINATION

PLEASE CONTACT US IF YOU REQUIRE INSTRUCTIONS REGARDING THE REFERRAL PROCEDURE
 - A release of information naming all parties to receive any information relating to this referral must be signed by the claimant / employee prior to commencement
 - Should you cancel this request, an administration and/or Provider cancellation fee may apply.

① INSURER / EMPLOYER INFORMATION		② REFERRING AGENCY INFORMATION (If Applicable)	
COMPANY NAME		WSIB <input type="checkbox"/> Yes Claim? <input type="checkbox"/> No	REFERRING AGENCY NAME
ADDRESS		ADDRESS	
CITY / TOWN	PROV	POSTAL CODE	CITY / TOWN PROV POSTAL CODE
CONTACT NAME		CONTACT NAME	
CONTACT PHONE	CONTACT FAX		CONTACT PHONE CONTACT FAX
POLICY # / CASE NUMBER OR WSIB CLAIM	INSURER / EMPLOYER FILE #		OTHER INFORMATION

Any **REPORTS** relating to this referral should be sent to: (Please check the applicable boxes below -If Other, please give Name and Address)

③a Insurer / Emp. Referring Agency Other:

The **INVOICE** for this referral should be sent to: (Please check **ONLY ONE** of the boxes below -If Other, please give Name and Address)

③b Insurer / Emp. Referring Agency Other:

④ CLAIMANT / EMPLOYEE INFORMATION		⑤ DETAILS OF IME, IPE OR FAE	
FIRST NAME	LAST NAME	SEX	<input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS		<input type="checkbox"/> MEDICAL SPECIALTY: _____ <input type="checkbox"/> FUNCTIONAL ASSESSMENT <input type="checkbox"/> WORKSITE ANALYSIS <input type="checkbox"/> TRANSFERABLE SKILLS ANALYSIS <input type="checkbox"/> HOME ASSESSMENT <input type="checkbox"/> FAE / FCE <input type="checkbox"/> ANY <input type="checkbox"/> OWN (PDA or Job desc. required)	
CITY / TOWN	PROV	POSTAL CODE	
HOME PHONE	BUSINESS PHONE		
DATE OF BIRTH (M/D/Y)	OCCUPATION		
EMPLOYER'S NAME (if different than (1) above)		PHONE	
DATE OF LOSS	CAUSE OF LOSS		

DIAGNOSIS: _____

COMMENTS: _____

TRANSLATOR REQUIRED: _____

TRAVEL REQUIREMENTS / RESTRICTIONS: _____

DATES CLAIMANT NOT AVAILABLE: _____

(Please forward a separate sheet with questions to be addressed)

PRIOR & CURRENT TREATING PHYSICIANS (list ALL!)	
Name	Phone

⑥ REQUEST TO PROCEED WITH INDEPENDENT MEDICAL EXAMINATION

I hereby declare that I am authorized to request this Independent Examination on behalf of the insurer / employer described in section 1 of this form. I further declare that I have received the appropriate authorization from the claimant / employee (named above in section 4) to release any and all information related to this assessment to CompreMed Canada Inc. and its agents for the purpose of performing this assessment and delivering the assessment report.

SIGNATURE

PRINT NAME

DATE

DO NOT WRITE BELOW THIS LINE



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REFERRAL / REQUISITION FOR MRI

NOTE: For other Diagnostic Services, please use the General Referral / Requisition

PLEASE CONTACT US IF YOU REQUIRE INSTRUCTIONS REGARDING THE REFERRAL PROCEDURE

- A release of information naming all parties to receive any information relating to this referral must be signed by the claimant / employee prior to commencement

- Should you cancel this request, an administration and/or Provider cancellation fee may apply.

① INSURER / EMPLOYER INFORMATION		② REFERRING AGENCY INFORMATION (If Applicable)	
COMPANY NAME		WSIB <input type="checkbox"/> Yes Claim? <input type="checkbox"/> No	REFERRING AGENCY NAME
ADDRESS		ADDRESS	
CITY / TOWN	PROV	POSTAL CODE	CITY / TOWN PROV POSTAL CODE
CONTACT NAME		CONTACT NAME	
CONTACT PHONE	CONTACT FAX		CONTACT PHONE CONTACT FAX
POLICY # / CASE NUMBER OR WSIB CLAIM	INSURER / EMPLOYER FILE #		OTHER INFORMATION

Any **REPORTS** relating to this referral should be sent to: (Please check the applicable boxes below -If Other, please give Name and Address)

③a CompreMed Canada Other:

The **INVOICE** for this referral should be sent to: (Please check **ONLY ONE** of the boxes below -If Other, please give Name and Address)

③b CompreMed Canada Other:

④ CLAIMANT / EMPLOYEE INFORMATION		⑤ DETAILS OF MRI	
FIRST NAME	LAST NAME	SEX	AREA TO BE EXAMINED (Check appropriate box(es)) <input type="checkbox"/> HEAD <input type="checkbox"/> LUMBAR SPINE <input type="checkbox"/> NECK <input type="checkbox"/> CERVICAL SPINE <input type="checkbox"/> UPPER EXTREMITY - <input type="checkbox"/> THORACIC SPINE <input type="checkbox"/> UPPER EXTREMITY - OTHER <input type="checkbox"/> THORAX <input type="checkbox"/> LOWER EXTREMITY - KNEE <input type="checkbox"/> ABDOMEN <input type="checkbox"/> LOWER EXTREMITY - OTHER <input type="checkbox"/> OTHER - (Detail below)
ADDRESS		<input type="checkbox"/> M <input type="checkbox"/> F	
CITY / TOWN	PROV	POSTAL CODE	
HOME PHONE	BUSINESS PHONE		
DATE OF BIRTH (M/D/Y)	OCCUPATION		
EMPLOYER'S NAME (if different than (1) above)		PHONE	
DATE OF LOSS	CAUSE OF LOSS		

COMMENTS:

TRANSLATOR REQUIRED: _____

TRAVEL REQUIREMENTS / RESTRICTIONS: _____

DATES CLAIMANT NOT AVAILABLE: _____

IMPORTANT NOTICE

Appropriate oral sedation should be provided to patients who may be prone to claustrophobia for administration 30 - 40 minutes prior to procedure.

⑥ REFERRING PHYSICIAN'S AUTHORIZATION TO PROCEED WITH MRI

I hereby declare that I am a physician authorized to request that this procedure be performed on behalf of the insurer/employer described in section 1 of this form and that the procedure be performed on the claimant / employee described in section 4 of this form. **PLEASE ENSURE THAT SECTION 5 ABOVE IS COMPLETED PRIOR TO SIGNING THIS SECTION.**

REFERRING PHYSICIAN SIGNATURE

REFERRING PHYSICIAN - PRINT NAME

DATE

⑦ REQUEST TO PROCEED WITH MRI

I hereby declare that I am authorized to request this Independent MRI on behalf of the insurer / employer described in section 1 of this form. I further declare that I have received the appropriate authorization from the claimant / employee (named above in section 4) to release any and all information related to this assessment to CompreMed Canada Inc. and its agents for the purpose of performing this assessment and delivering the assessment report.

SIGNATURE

PRINT NAME

DATE

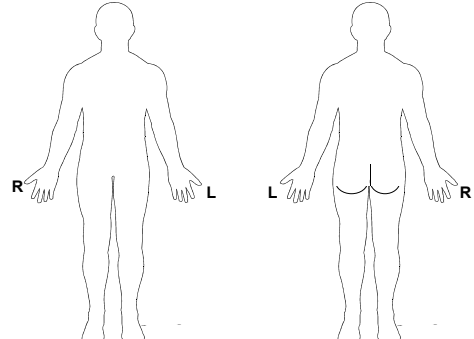
M.R.I. SCREENING INFORMATION

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This form must be filled out completely and signed by the claimant prior to any MRI procedure being done.

SECTION A CLAIMANT / EMPLOYEE INFORMATION			
NAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	HOME PHONE	BUSINESS PHONE
DATE OF BIRTH (M/D/Y)	WEIGHT	IS THIS A W.C.B. CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, PLEASE GIVE W.C.B. CLAIM NUMBER
	HEIGHT		

SECTION B PLEASE ANSWER ALL QUESTIONS IN THIS SECTION	
<i>If you answer yes to any of the following questions, please give details in the space provided.</i>	
<p>1. Have you ever been a welder, grinder, or metal worker? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>2. a) Have you ever had a metallic foreign body in your eye? <input type="checkbox"/> YES <input type="checkbox"/> NO b) If yes, was the foreign body removed? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>3. Is there any chance that you may be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>4. Are you claustrophobic? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>6. Have you ever had any surgery? (please describe below) <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Do you have any of the following below?</p> <p>cardiac pacemaker (specify type below) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>heart valve replacement <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>aneurysm clips (specify type below) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>neurostimulator <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>shrapnel or bullets <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>surgical rods or staples <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>I.U.D. (specify type below) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>hearing aid <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>dentures / retainers <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>prosthesis (limb, joint, eye, ear) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>other implanted devices <input type="checkbox"/> YES <input type="checkbox"/> NO</p>
If yes to any of above, give details	If yes to any of above, give details
CLAIMANT / EMPLOYEE SIGNATURE - must be signed and dated _____ DATE _____	

SECTION C PLEASE ANSWER ALL QUESTIONS IN THIS SECTION IF YOU ARE HAVING AN MRI OF THE SPINE	
<p>1. What was your main complaint when you visited the Doctor?</p> <p>2. Describe your pain (i.e. burning, sharp, aching, dull, etc.)</p> <p>3. Does the pain go down your arm or leg? _____ In the front or back? _____ Left, right, or both? _____</p> <p>4. Does anything make it worse (ie. standing, sitting, lying down, etc.)</p> <p>5. Do you have any numbness? _____ Where? _____ Any weakness? _____ Where? _____</p> <p>6. Have you had any bowel or bladder changes? _____ Describe _____</p> <p>7. What do you think caused the problem?</p> <p>8. When you wake in the morning, is your pain better or worse?</p> <p>9. Have you had any spine surgery? _____ When? _____ What was done? _____</p> <p>10. Do you have any other medical condition?</p> <p>11. Describe your general health.</p>	<p><i>Please shade in the areas that are involved on the diagrams below</i></p> <div style="text-align: center;">  <p>Front Back</p> </div>



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DECLARATION OF THIRD-PARTY ELIGIBILITY

This declaration must be filled out and signed by the claimant's insurer or employer or the insurer's agent and sent to CompreMed prior to acceptance of any referral.

GENERAL INSTRUCTIONS

CompreMed Canada Inc. will only provide services that are permitted under the Canada Health Act and relevant provincial health insurance regulations. CompreMed therefore requires every agency referring claimants for third-party services (such as diagnostic imaging, etc.), to establish and guarantee for CompreMed the claimant's eligibility as a primary and essential step in the referral process. It is the responsibility of the referring agency and the agency's employee and/or agent preparing the referral, to establish the eligibility of the claimant as a legitimate candidate for third-party healthcare service under the relevant Federal and Provincial legislation, as only the referring agency has access to the necessary information.

CompreMed is unable to provide third-party services unless and until such confirmation is received.

Accordingly, after establishing the claimant's eligibility, please indicate the appropriate category of eligibility, and endorse the confirmation with the signature of an authorized agent of the referring agency before forwarding this form to CompreMed.

DECLARATION OF CLAIMANT THIRD-PARTY ELIGIBILITY

I have established and I hereby declare that the service(s) requested for:
(print claimant's name) _____, referred to CompreMed Canada in the attached referral form is not medically necessary and is a legitimate third-party service because the service is required; **1)** for the production or completion of a document, **OR 2)** for the transmission of information to a person other than the insured person, **AND** the document or transmission relates to: (check one or more boxes below where appropriate)

- an application for, or a continuation of, insurance
- an entitlement to benefits, including insurance benefits or benefits under a pension plan
- obtaining or continuing employment
- an absence from, or return to, work
- legal proceedings
- an application for, or a continuation of, a license
- entering or maintaining a contract
- admission to or continued attendance in a daycare or pre-school program or a school, community college, university, or other educational institution or program
- admission to or continued attendance in a recreational or athletic club, association or program or a camp

Authorized Signature

Print Name

Date



CLAIMANT / EMPLOYEE AUTHORIZATION FORM

This authorization form must be filled out and signed by the claimant / employee prior to any assessment.

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I, _____ hereby consent to an *(see options below)*:
(print first and last name)

- Independent Medical Examination**
- Independent Medical Consultation**
- Independent Psychological Examination**
- Functional Abilities Evaluation**
- MRI**
- CT Scan**
- X-Ray**
- Other: (please indicate):** _____

that will be performed by: _____
(Physician or institution name)

I understand that this assessment will be performed on behalf of my insurer or employer and that the report formulated from this examination remains their property.

I understand that the examination report cannot be discussed with or released to me or any other party without prior authorization of: _____
(print insurer's or employer's name)

I understand that although this examination is not medically necessary, my insurer or employer has requested that it be performed in order that they may better understand the issues relating to my claim for benefits.

I understand that personal information about me that is pertinent to this assessment will be released to CompreMed Canada Inc. and its agents for the purpose of performing this assessment and delivering the assessment report to my insurer or employer. I hereby authorize the release of such information.

_____ Signature	_____ Print Name	_____ Date
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_____ Signature of Witness	_____ Print Name	_____ Date
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