JURIS SOLUTIONS Inc.
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Expert Witnesses and Independent Medical Exams

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*"Put Your Expert Needs In Our Expert Hands."*

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# IME REQUEST FORM

Circle: Physical Exam(s) / Record Review only / Radiology Review

Date: ____________________________

Claim No.: ______________________

Date of Injury: ___________

Insured/Defendant: _______________

Type of Case: (Tort)(BI)(FFD)(DIS)(COMP)(No-Fault)

Testing to date:__________________

________________________________

________________________________

Plaintiff/Claimant: __________________________

Address: ____________________________________

______________________Phone: ______________

Plaintiff's Attorney: _________________________

Address: ____________________________________

____________________________________________

Phone: _______________ Fax: _______________

☐ Contact Plaintiff Directly ☐ Attorney Only

Venue: ______________________________________

Prior/Subsequent conditions/injuries: ________________________________________________

**MEDICAL SPECIALTY:**

Treating Physician: __________________________

☐ Orthopedist ☐ PM&R ☐ Dentist ☐ ENT
☐ Neurologist ☐ Internist ☐ TMJ ☐ Radiologist
☐ Psychiatrist ☐ Chiropractor ☐ Plastic Surgeon Other____________

*Please supply background medical records and Bill of Particulars/Complaint.

☐ Physician is authorized to perform x-rays or other testing in conjunction with this exam?

Specify: ________________________________

**ISSUES TO BE ADDRESSED:**

☐ Causal Relationship ☐ Return to Work/ ADL ☐ Schedule Loss Eval. (Comp)
☐ Degree of Disability ☐ Permanence ☐ Apportionment (Comp.)
☐ Need for Treatment/Testing ☐ Need for Surgery ☐ M&S Issues (Comp.)

**Specific Issues to Address and Instructions:** ____________________________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

**Client Name:** ______________________

______________________________________

Address: ___________________________

______________________________________

Contact:_____________________________

Phone: ___________ Fax: _____________

Attorney: ___________________________

Phone: ___________ Fax:_____________

**Billing Address if Different:** ______________

__________________________________________

__________________________________________

__________________________________________

Contact: ___________________________________

Phone: __________________ Fax: ____________

*Note: Unless otherwise specified, the report will be addressed to JurisSolutions, Inc.

We appreciate your referral and respectfully request that payment be remitted within 30 days.

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