

RALEIGH HAND CENTER, P.A.
3404 Wake Forest Road, Suite 303
Raleigh, NC 27609

Phone: (919)872-3171 Fax: (919)872-6739

George S. Edwards, Jr., M.D.
Jon Kolkin, M.D.
James R. Post, M.D.

Paul O. Schricker, M.D.
Terry M. Messer, M.D.

Worker's Compensation Request Form

In addition to your usual cover letter, it will greatly expedite our review and scheduling if you provide the following preliminary information. **NOTE: There will be a \$100.00 charge in the event that an appointment is not canceled prior to the 48 hours of the scheduled time. If the requested x-rays, reports, etc. are not present at the time of the appointment, the appointment will be rescheduled at the doctor's discretion and a \$100.00 rescheduling fee will be assessed.** **PAYMENT MUST TO BE MADE PRIOR TO RESCHEDULING.**

Thank you.

Patient's Name: _____ Phone #: _____

Patient's Date of Birth: _____

Employer Name & Address: _____

Date of Injury (or onset of symptoms): _____

Diagnosis: _____

Brief outline of treatment to date:

Current work status: _____

Purpose for referral (i.e. IME, 2nd opinion, treat, PPD rating): _____

Adjuster: _____ Phone #: _____ ext. _____ Fax# _____

Case Manager: _____ Phone #: _____ ext. _____ Fax# _____

Claim# _____

Billing Info: Insurance Company

Name & Address: _____

Please indicate if an initial therapy visit in our office (if required) is approved _____

PLEASE INDICATE IF YOU ARE REQUESTING A SPECIFIC DOCTOR TO REVIEW THE NOTES. _____