



ARCADIA RADIOLOGY MEDICAL GROUP

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www.ArcadiaRadiology.com

STAT

- Stat Appointment
Fax to: (626) 447-2924
- Call Dr. With Result
At: ()
- Report Only
Fax: ()

WORKERS' COMPENSATION REFERRAL FORM



Today's Date: _____

DEMOGRAPHICS

Patient Name: _____ DOB: _____

Primary Phone: _____ Secondary Phone: _____

CLINICAL INFORMATION

Signs & Symptoms: _____

Exam Requested: _____

Patient History: _____

If patient had previous exam- When: _____ Where: _____

Has patient had prior surgery related to exam: Yes No * Sedation Needed? Yes No

Describe: _____

History of Cancer: _____

WORKER'S COMPENSATION

Insurance Carrier: _____ Claim: _____ Date of Injury: _____

Billing Address: _____ Employer at Time of Injury: _____

Authorized By: _____ Phone: _____

REFERRING OFFICE CONTACTS

Copy of Report to: _____

Special Instructions: _____

Physician Signature: _____

PRINT OR OFFICE STAMP

Physician Name:

Phone:

Fax:

APPOINTMENT

Appointment Date: _____ Appointment Time: _____

Location: Arcadia Radiology Medical Group, 612 West Duarte Road, Suite 101, Arcadia, CA 91007