**Referral Information**

**Our physicians reserve the right to review all medical records and have clinic in WIRC either on a weekly or bi-weekly basis. Acute referrals will be addressed within 24-48 hours; all other referrals will be addressed within 5-7 business days.**

**Records should be sent to fax: 319-356-1193 or email:** **uiwirc@uiowa.edu**

**Any questions please contact WIRC at 319-356-1113, Tax ID: 42-6004813. Thank you!**

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| --- | --- |
| ***Provider Preference:*** ***Referral requested by:******Purpose of Referral:******APP/MID-LEVEL Authorized to start*** Yes [ ]  No [ ]  | **Consult Only [ ]  Eval & Treat [ ]**  **2nd Opinion [ ]  Independent Med Eval [ ]** **PPI Only [ ]  Causation Opinion [ ]** **Interpreter Needed?** Yes [ ]  No [ ]  Language:      **Please check box to confirm interpreter will be provided:** Yes [ ]   |
| ***PATIENT INFORMATION*** | ***EMPLOYER INFORMATION*** |
| **DOB:**       | **Company**:       |
| **Name:**       | **Job Title**:       |
| **Address:**       | **Contact**:       |
| **City, State, Zip:**       | **Phone**:       |
| **Phone**:       | **Fax**:       |
|  |  |
| ***REFERRING PHSYICIAN*** | ***CLAIM INFORMATION*** |
| **Clinic**:       | **Claim #:**       |
| **Phone**:       | **Date of Injury:**       |
| **Fax**:       | **Injured Body Part Covered:**       |
|  |  |
| ***WC INSURANCE***  | ***CASE MANAGER*** |
| **Company:**       | **Company:**       |
| **Adjuster Name:**       | **Case manager Name:**       |
| **Billing Address:**       | **Billing Address:**       |
| **City, State, Zip:**       | **City, State, Zip:**       |
| **Contact Phone:**       | **Contact Phone:**       |
| **Contact Fax:**       | **Contact Fax:**       |
| **E-mail:**       | **E-mail:**       |
|  |  |
| ***ATTORNEY*** | ***Representing Claimant***[ ]  ***Employer*** [ ]  |
| **Firm:**       | **Phone:**       |
| **Address:**       | **Fax:**       |
| **City, State, Zip:**       | **Email:**       |
|  |  |