**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**](mailto: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:** |
|  |  |