

PACBLU CALIFORNIA SERVICE REQUEST	Forward referral via one of the following Fax: 503.534.3554 Mail: 4800 SW Meadows Rd., Ste 300 Lake Oswego, OR 97035 Email: vsnodgrass@pacblu.com
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Requested Specialist		Date	
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Medical Case Management	Vocational Rehabilitation
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Limited Assignment	Full Field Case Management	Telephonic Case Management
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Task assignment(s): please check all that apply

<input type="checkbox"/>	Attend Physician's Appt.	<input type="checkbox"/>	Obtain Work Restrictions	<input type="checkbox"/>	Obtain Medical Records
<input type="checkbox"/>	File Review	<input type="checkbox"/>	Life Care Plan	<input type="checkbox"/>	Transferable Skills Analysis
<input type="checkbox"/>	Labor Market Survey	<input type="checkbox"/>	Transitional Work Assessment	<input type="checkbox"/>	Ergonomic Assessment
<input type="checkbox"/>	Job Analysis	<input type="checkbox"/>	Future Care Cost Projection	<input type="checkbox"/>	Other
<input type="checkbox"/> Initial Review /Assessment Only - please contact me to discuss service options					

CLAIM TYPE: please check below

<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/>	General Liability	<input type="checkbox"/>	Long Term Disability	<input type="checkbox"/>	Auto	<input type="checkbox"/>	Group Health
<input type="checkbox"/> Other: (please specify)									

INSURANCE CARRIER

Company: _____
 Adjuster: _____ Phone: _____
 Fax: _____ Email: _____

CLAIMANT / Please complete or attach WC-1

Name: _____ Phone: _____
 Address: _____
 DOI: _____ Claim #: _____ Occupation: _____
 Primary ICD9: _____ Description of Injury: _____
 DOB: _____ SSN: _____ Claimant advised of our involvement? Y N

EMPLOYER / Please complete or attach WC-1

Employer: _____
 Contact: _____ Phone: _____

PHYSICIAN	CLAIMANT ATTORNEY
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Name: _____ Name: _____
 Attorney advised of our involvement? Y N

Special Instructions/Goals: