

PACBLU

Referral - Service Form

Forward referral via one of the following
 Fax: 808.955.2925
 Mail: 1357 Kapiolani Blvd., Suite 1015
 Honolulu, HI 96814
 E-mail: htadaki@pacbluhawaii.com
 Website submission:
<http://www.pacbluhawaii.com/request/form.htm>

Requested Specialist: _____ Date: _____

Medical Case Management

Vocational Rehabilitation

Limited Assignment

Full Field Case Management

Telephonic Case Management

Task Assignment(s): Please check all that apply

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

CLAIM TYPE: please check below

Worker's Compensation	General Liability	Long Term Disability	Auto	Group Health
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: _____
 DOB: _____ SSN# _____ Claimant advised of our involvement? Y N

EMPLOYER / Please complete or attach WC-1

Employer: _____
 Contact: _____ Phone: _____

PHYSICIAN CLAIMANT ATTORNEY

Name: _____ Name: _____
 Attorney advised of our involvement? Y N

Special Instructions/Goals

Internal Use Only