

8821 University East Drive, Suite 120, Charlotte, NC 28213 
\* Tel: (704) 428-9006 \* Fax: (704) 599-0998

Email: patientcare@apmr3.com

## **Personal Injury Referral Form**

## **Patient Information:**

Full Name:		Date of Injury:		
Pat	First MI Last tient Mailing Address:	City:	State:	Zip:
Phone#:DOB:		Female: Male:		
Referred by:		_ Referral Source Phone#		
Pa	tient Intake Questionnaire: (please check one)			
1.	Was the patient injured in an auto accident	☐ Yes	☐ No	
2.	Is the patient being represented by an attorney?	☐ Yes	☐ No	
	If yes, please list Law Firm representing the patient:			
	Law Firm Name:	Telephone #:		
	Firm Address:	City, State, Zip:		
	Case Manager Name:	Case Manager	Ph#:	
	Case Managers Email Address:	Case Manger Fa	ax#	
3.	Is treatment covered by worker's compensation?	☐ Yes	☐ No	
	If yes, Insurance Carrier Name:	Adjuster Na	ıme:	
	Address:	City, State, Zip:		
	Claim#: Phone	e#:		
Pro	esent Complaints:			
Ple	ease describe the patient's complaints:			<del></del>
Did the patient go to the hospital?  Yes  No (If yes, what hospital?)				
На	s the patient received any other medical treatment?	Yes No (If yes, the	e Name & Phone	# of other
doctors)				
Internal Use Only:				
Annointment Scheduled: Date Time:				