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Western Medical Assessments

DISABILITY SERVICES REQUIRED

- o Evaluation *(type)* _____
- o Independent Medical Examination *(type)* _____
- o Functional Capacity Evaluation
- o Document Review
- o Other *(type)* _____

City: o Edmonton o Calgary o Fort McMurray o Vancouver o Saskatoon o Other

CLAIMANT Surname _____ First Name _____
Fluent in English o Yes o No Language Spoken _____

Address _____ City _____ Prov. _____ Postal Code _____
Home Tel _____ Other Tel _____
E-mail _____ Date of Birth _____

CLIENT INFORMATION Company Name _____
Case Manager _____ Alternate Contact _____
Direct Tel _____ Fax _____ Email _____
Address _____ City _____ Prov. _____ Postal Code _____
Claim Number _____ Date of Disability _____

CLIENT CONCERNS _____

Is claimant working? o No o Part-time o Full-time

Are they working modified duties? o Yes o No
Return to work issues? o Yes o No

CURRENT COMPLAINTS _____

DOCUMENTATION TO FOLLOW o Yes o No
Waybill Provided? o Yes o No

Please be advised to include your waybill if you require the documentation to be returned. If a return waybill is not provided, the documentation will be destroyed 30 days after the assessment.

SCHEDULING OF APPOINTMENT
Case to be discussed prior to appointment being set? o Yes o No

Date of Report Deadline _____

To be scheduled with claimant? o Yes o No
To be scheduled with client? o Yes o No

TERMS AND CONDITIONS

1. A file opening fee may be charged to Client, to include but not limited to Medical Director's fee, admin and/or clerical time, long distance and other disbursements.
2. Payment for services rendered is due upon receipt of invoice, net 30 days. Payments are to be addressed to Western Medical Assessments, 17204 106A Avenue, Edmonton, Alberta, T5S 1E6
3. Any late cancellation (date will be stipulated in our letter with Appointment details) or no-show fee is the Client's responsibility to cover, terms as in number 2 above.

_____ _____
SIGNATURE DATE