Orthopedic & Neurologic Impairment Ratings
PO Box 4667
Roswell, NM 88202
Phone: (575) 317-3622 Fax: (575) 613-7247
email: ir@oni.org url: www.oni.org

Impairment Rating Referral Form

_____
Client (Patient) Full Name:

_____
Client Mailing address:

_____
Contact telephone number:

_____
Alternate telephone number:

_____
Employer & Job Title on DOI:

_____
Current Employer & Job Title:

_____
Current work status:

_____
Referring Practice:

_____
Practice Mailing Address:

_____

Practice Telephone number:

_____
Practice Fax number:

_____
Practice email address:

_____
Date of injury (DOI):

_____
Workers Compensation (WC) Carrier:

_____
WC Claim Number:

_____
WC Insurance Carrier Contact:

_____
WC Contact Address:

_____
WC Contact Telephone Number:

_____
WC Contact Fax Number:

_____
WC Contact email address:

Records to be submitted:

1) Medical record of first visit for covered injury (ED, MD, whatever).
2) If patient has more than one injury or complaint, an explicit statement of which one(s) to be rated
3) Reports of all related xrays, MRI's, and any other diagnostic studies.
4) Operative report(s) of all surgery related to the injury.
5) Medical record from date worker was returned to work.
6) Medical record from date of determination of MMI.

Please contact us for further information on IME's.