REQUEST FOR APPOINTMENT OF INDEPENDENT MEDICAL EXAMINER, REHABILITATION EVALUATOR, OR MEDICAL CASE MANAGER

COURT FILE NO.	Claimant's Social Security No.
Full Name of Claimant (Injured Employee)	
Claimant's Mailing Address	
City State Zip Code	
Claimant's Date of Birth	Claimant's Telephone Number ( )
Name of Treating Physician	
Treating Physician Mailing Address	
City State Zip Code	

THIS SPACE FOR COURT USE ONLY: Revised 7/23/10
IME Physician or Rehabilitation Evaluator or Medical Case Manager
BODY PARTS
Name of Respondent (Employer)
Name of Insurer
Date of Injury
IME Requested By: ☐ Claimant ☐ Respondent ☐ Court on its own motion ☐ Mutual Agreement
IME Physician Selected By: ☐ Parties ☐ Court

Issues:

1.____ IS THE TREATING PHYSICIAN'S OPINION/REPORT, DATED _____*(insert date)*, SUPPORTED BY OBJECTIVE MEDICAL EVIDENCE? IF NOT, SUBMIT A VERIFIED OR DECLARED WRITTEN NARRATIVE REPORT TO THE COURT AND THE PARTIES ADDRESSING ONLY THE FOLLOWING ISSUE(S*) [specify issue(s)]*:

a.___ Is the claimant currently temporarily totally disabled?
b.___ Was claimant temporarily totally disabled from _____ to _____?
c.___ Is claimant in need of additional treatment? Treatment is not authorized.
d.___ Does claimant need pain management?
e.___ Diagnostic testing that is reasonable and necessary to respond to the issues specified in this order is authorized.
f.___ Physician is requested to make specific recommendations regarding treatment, including any necessary maintenance care.
g.___ If treatment is not needed, or if claimant has reached maximum medical improvement, physician is requested to rate nature and extent of permanent partial impairment, if any.
h.___ Physician is requested to address causation.
i.___ Physician is requested to address the issue of apportionment, if applicable.
j.___ Physician to address whether the claimant has suffered a change of condition for the worse.
k.___ Physician to address whether the claimant is permanently and totally disabled.
l.___ Physician to address whether vocational rehabilitation is indicated (i.e. whether as a result of the injury the claimant is unable to perform the same occupational duties the claimant was performing before the injury).

2.____ PER 85 O.S., SECTION 14(J), PHYSICIAN IS TO DETERMINE THE NATURE AND EXTENT, IF ANY, OF CONTINUING MEDICAL MAINTENANCE.

3.____ PER 85 O.S., SECTION 17(D)(10), IS THE CLAIMANT IN NEED OF FURTHER MEDICAL TREATMENT? PHYSICIAN IS REQUESTED TO MAKE SPECIFIC RECOMMENDATIONS REGARDING TREATMENT. TREATMENT IS NOT AUTHORIZED.

4.____ PHYSICIAN IS TO REVIEW THE MEDICAL RECORDS OF THE EMPLOYEE, EXAMINE THE EMPLOYEE, OR BOTH, AS NECESSARY TO RENDER AN OPINION PER 85 O.S., SECTION 201.1 ON WHETHER OR NOT PRIOR AUTHORIZATION SHOULD BE GRANTED FOR TREATMENT OUTSIDE TREATMENT GUIDELINES ADOPTED AS PROVIDED IN TITLE 85 OF THE OKLAHOMA STATUTES.

5.____ Medical examination of the claimant by the independent medical examiner is authorized by agreement of the parties.

6.____ Counselor is to perform rehabilitation evaluation, including recommendation for vocational retraining plans, if appropriate.

7.____ Counselor is to determine transferable skills.

8.____ Counselor is to provide job placement assistance.

Special Instructions:_____

_____	_____
Claimant's Attorney, if represented OBA#	Judge
_____	_____
Respondent's Attorney OBA#	Date