Referral for Services

PO Box 2116
Antioch, CA 94531
Phone: 800-746-4364 Fax: 925-602-8993
Email: REFER@DMGWorks.com

EMPLOYEE	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
CLAIM # (if applicable)	
DOI (if applicable)	
JOB TITLE	
EMPLOYER	
ADDRESS	
CITY/STATE/ZIP	
SUPERVISOR	
PHONE	
EMAIL	
PHYSICIAN	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	
EMAIL	
DEFENSE ATTY.	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	
EMAIL	
APPLICANT ATTY.	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	
EMAIL	

REFERRAL FROM	**Date:____/____/____**
COMPANY	
CONTACT	
ADDRESS	
CITY/STATE/ZIP	
PHONE	
FAX	
EMAIL	

SERVICE(S) REQUESTED	
	Job Description
	Job Description and Physician Follow Up *(specific to Workers' Compensation claim)*
	Essential Function Job Analysis
	Permanent Modified/Alternative Work Meeting *(specific to Workers' Compensation claim)*
	Return-to-Work assistance (transitional RTW)
	OTHER:

Notes / comments: