TRS WORKSITE SOLUTIONS

TESTING REFERRAL FORM

FCE Requestor Name: _____ Company: _____

Phone & Email: _____

Who Pays: □ Employer □ Carrier □ TPA □ Attorney □ Other _____

Workers Comp Carrier: _____ Claim #: _____ Pre-Auth #: _____

Adjuster Name & Contact _____

Name of Person Being Tested: _____ DOB: _____

Phone: _____ Email: _____ Text: _____

Purpose of Test: _____

Specific Questions to Answer: _____

Employer Name: _____ Employer Address: _____

Job Title: _____ Job Description/PDA Provided: □ Yes □ No

If yes, please email to fce@trs-works.com

Diagnosis: _____ Treating Physician: _____

Date of Injury: _____ Current Restrictions: _____

Requested Test(s): □ FCE □ Impairment Rating □ Post-Offer □ Fit For Duty □ RTW □ Other

Jurisdictional State of Referral: _____ Attorney Represented: □ Yes □ No Name: _____

Signature: _____ Printed Name: _____ Date: _____