Department of Labor and Industries
Claims Section
PO Box 44319
Olympia WA 98504-4291

CONSULTATION REFERRAL

To: (Consultant's name)	Patient history summary for: Transfer ❑ Consultation ❑	Claim #:
Name:	DOI:	Date of first treatment:
Nature of work:	Employer:	

History of injury and/or attach a copy of accident report:

Accepted condition: (diagnosis)

X-ray findings:

Time loss:

Previous attending physicians for this injury:

Care provided to date:

Progress to date: (Include change in subjective & objective findings compared to onset of accepted condition.)

Requested by: (attending doctor)	Date:	❑ Letter ❑ Phone

Reason for consultation:	❑ Clinical issues	❑ 120 day consultation	❑ Closing	❑ Other

An appointment has been made with:	Date:	Time:

****Claimant****

To be completed by Attending doctor - Attending doctor, tear & send lower portion to claimant

An appointment has been made with:

Phone:

Date: Time:

**I understand that failure to keep this appointment may jeopartize further benefits on my claim.

(Claimant's Signature)

White – L&I Headquarters
Canary – Consultant prior to appointment date
Pink – Attending Doctor