AMIRA Medical Staffing

Referral Form

Date Referred: _____ **Date of Injury:** _____

Referral Type: ☐ Medical ☐ Other: _____

Claim Type: ☐ Worker's Compensation ☐ Auto No-Fault ☐ Other: _____

Claimant Information

Name (First, Middle, Last): _____

Social Security Number: _____ Claim Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of Birth: _____

Claims Representative

Name: _____

Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Medical Information

Treating Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Diagnosis:

Surgery Date (if applicable): _____

Employment Information

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____ Average Weekly Wage: _____

Contact Name: _____ Contact Phone Number: _____

27602 Ford Rd, Garden City, MI 48135 - P: (866) 942-6742 F: (734) 266-3023

Attorney Information

Attorney name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

☐ Please contact me to make accommodations to retrieve additional medical documentation.

Comments (add specific requests here):

Submit Form

You may also fax this form to: (734) 266-3023

27602 Ford Rd, Garden City, MI 48135 - P: (866) 942-6742 F: (734) 266-3023