

Provide specifics about each test or referral ordered.

**Part 2**

**Referrals and Testing or Evaluation**

I [sent/did not send] the injured employee to another health care provider for testing or evaluation necessary to complete this designated doctor exam.



	<b>Referral Health Care Provider Name</b>	<b>Provider License Number</b>	<b>Date of Service</b> (mm/dd/yyyy)	<b>Type of Testing</b> <i>Functional capacity evaluation (FCE), electromyography (EMG), nerve conduction velocity (NCV), magnetic resonance imaging (MRI); computed tomography (CT) Scan, Describe other testing.</i>
1.				
2.				
3.				
4.				
5.				

Discuss findings.

**Analysis of Results of Referral for Testing or Evaluation**

**Referral 1.**

Referral health care provider name: [Name]  
Health care provider license number: [License number]  
Date of service: [mm/dd/yyyy]  
Type of referral or test: [Type]  
Reason for referral or test to resolve a question: [Reason]

**Analysis of referral or test findings**