Washington State Department of Labor & Industries

Attending Provider's Referral Form

This form is an optional communication tool intended for use in facilitation of second opinion consultations, specialty referral consultations, concurrent care referrals, or closing exams with impairment ratings.

Do not request a referral or consultation if an IME has been ordered. Obtain claim manager authorization for concurrent care before scheduling the patient. Consultations (other than for mental health) do not require prior authorization.

Worker Information

Worker's Name		Claim Number
Worker's Preferred Language	Worker's Phone Number	Date of Injury
Current Work Status ☐ Full Duty ☐ Modified Duty ☐ Not working for medical reasons ☐ Not working – light duty not available		
Accepted Condition(s) – Include ICD Codes		
Claim Manager Name	Claim Manager Phone Number	

Attending Provider Information

Attending Provider's Name	NPI (*optional)*	AP Phone Number
AP's Business Address	City	State Zip Code
Supporting Attachments (as appropriate) ☐ Patient Demographic Page ☐ Accident Report ☐ Activity Prescription Form(s) ☐ Imaging, Laboratory Report ☐ Consultation, IME, Progress Reports ☐ CM Authorization(s)		

Reason for Referral

Referral Reasons (mark all that apply)

☐ Diagnostic uncertainty
☐ Progress stalled – care options sought
☐ Return to work issues
☐ Specialty/Surgical Consultation
☐ Impairment Rating – CM authorization required, consultant must be an approved examiner
☐ Consultation for appropriateness of continuing care – required prior to 120 days following 1st visit or beyond 20 visits
☐ Other:

Concurrent Care Request Information

Role of concurrent care provider

Specific clinical/functional improvement goals for concurrent care
Expected duration of concurrent care

Referral/Concurrent Care Provider Information

Referral/Concurrent Care Provider's Name	Specialty	Phone Number	
Business Address	City	State	Zip Code
Appointment Date	Appointment Time		

Continuity of Care / Clinical Summary

Use this form or follow this outline for a separate, attached referral letter, or send the discussion/summary section from your EHR.

Injury/Exposure History
Treatment Date
Progress to Date: Indicate improvements in function and findings since the DOI and when you initiated care
Key Concerns/Issues/Questions for Referral Provider

Attending Provider Signature

Signature	Date

Next Steps

1. AP Office – Send a copy of this entire form to L&I
2. Consultant – Call CM for Claim & Account Center (CAC) access or approval of concurrent care.

☐ CM Notified of Referral
☐ CM Agreed to Concurrent Care
☐ Other CM Assistance Requested

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