Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

ATTENDING PROVIDER'S REFERRAL FORM

This form is an optional communication tool.

For:
- ☐ 2nd Opinion Consultation
- ☐ Specialty/Surgical Consultation
- ☐ Concurrent Care (authorization required)
- ☐ Transfer of Care Consultation
- ☐ Closing Exam and Impairment Rating

Attending Provider: Do not request referral or consultation if IME has been ordered. Obtain CM authorization for concurrent care before scheduling patient. Consultations (other than mental health) do not require prior authorization. Send copy of this entire form to L&I and give bottom section to the worker.

Staff of Provider Complete

Worker's Name	Accepted Condition(s) (*Include ICD Codes*)	DOI	Claim #

Worker's Occupation

Current Work Status:
- ☐ Full duty
- ☐ Modified Duty
- ☐ Not working for medical reasons
- ☐ Not working – light duty not available

Claim Manager's (CM) Name | Phone
- ☐ CM Notified of Referral
- ☐ CM Agreed to Concurrent Care
- ☐ Other CM Assistance requested

Attending Provider's Name	Phone	Referral/Concurrent Care Provider's Name* (*For WA, must be in L&I Provider Network*)	Phone

Business Address

Specialty

Business Address

Required Attachments
- ☐ Accident Report
- ☐ Activity Prescription Form(s)
- ☐ Imaging, Laboratory Reports
- ☐ Consultation, IME, Progress Reports
- ☐ CM Authorization(s)

Appointment Date	Appointment Time

*To review the claim file, contact the CM to obtain temporary access to the Claim and Account Center

Provider Complete

Referral Reasons (*Mark all that apply*)
- ☐ Diagnostic uncertainty
- ☐ Treatment plan uncertainty
- ☐ Progress stalled, care options sought
- ☐ Return-to-work issues
- ☐ Consultation for appropriateness of continuing care (*required prior to 120 days following 1st visit or beyond 20 visits*)
- ☐ Assessment for maximal improvement
- ☐ Other

If Concurrent Care requested:

Role of concurrent care provider:

Specific clinical/functional improvement goals for concurrent care:

Expected duration of concurrent care:

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 to 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's Signature	Date

AP: Copy the signed form to send to L&I and give following section to worker

An appointment has been made for you with:
Name

Address

Specialty	Phone

Appointment Date:	Appointment Time

I understand that failure to complete this consultation or referral may jeopardize future benefits on my claim.

Worker's Signature

Date