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IME File Review CE Psychological MSE IDE Other
Province: AB BC MB SK Other Country

City: Calgary Edmonton Vancouver Victoria Regina Saskatoon Winnipeg Other

CLAIMANT (Surname) (First Name) D.O.B MM/DD/YY

Fluent in English Yes No Language Spoken Male Female

Address City Province

Postal Code Home Tel Other Tel

Return to Work Issues: Yes No Occupation Retired: Yes No

DATE OF LOSS File / Claim No. MM/DD/YY

CLIENT (Company Name)

CONTACT (Name)

Address City Province

Postal Code Tel Fax Email

CLAIMANT'S LAWYER (Law Firm Name)

LAWYER (Name)

Address City Province

Postal Code Tel Fax Email

INJURIES / COMPLAINTS

CLIENT'S CONCERNS (please provide details in separate letter if required)

IF THERE IS AN ABSOLUTE DEADLINE FOR THE REPORT, PLEASE ADVISE US NOW.

CLIENT'S SIGNATURE Date

IMPORTANT Notes to Client: A file opening fee may be charged to Client, to include but not limited to Medical Director's Fee; admin and/or clerical time; long distance and other disbursements. PLEASE READ OUR TERMS AND CONDITIONS. Client's initials

Once Western Medical Assessments has reviewed the Request and information, should the case be discussed with the Client prior to making the Assessment Appointment with an appropriate specialist? Yes No

How should the Appointment be scheduled and confirmed? Please select only one of the following:
a) Directly with Claimant? Yes No
b) Through Client, who will then deal with Claimant? Yes No
c) With Claimant's Lawyer, who will then deal with Claimant? Yes No

How did you inform the Claimant that the Assessment is imminent? Date

In order to provide you with our best service, please:
• Enclose all available medical and other related information when sending in this form;
• Advise the Claimant that you're making arrangements for an Assessment through Western Medical Assessments;
• And, if the Claimant has a Lawyer, please ensure that he/she agrees.