BioFunction™
Formerly KEHS

CASE REFERRAL FORM

ALLIANCE OCCUPATIONAL MEDICINE

Insurance Carrier	**Patient's Name**
Street Address	**Street Address**
City, State, Zip	**City, State, Zip**
Telephone Number **FAX Number**	**Telephone Number**
Claims Adjuster	**Social Security #** **Occupation**
Date Referral	**Date of Birth** **Sex**
Date of Injury	**Claim #**

Treating Physician	**Employer**
Street Address	**Street Address**
City, State, Zip	**City, State, Zip**
Telephone Number **FAX Number**	**Telephone Number**
Diagnosis **ICD-9 Code(s)**	**Contact Person**

Defense Attorney	**Applicant's Attorney**
Street Address	**Street Address**
City, State, Zip	**City, State, Zip**
Telephone Number	**Telephone Number**

Special Instructions:

SELECT SERVICE

- ☐ **Work Capacity Evaluation**
- ☐ **Functional Restoration Baseline Exam**
- ☐ **Functional Restorative Therapy [2 weeks]**
- ☐ **Forensic Myotonometry**

Nurse Case Manager (Name, Address, Phone & Fax):

The above patient is:

☐ **Yes** **Able To Participate**
☐ **No** **Unable To Participate Due To:**

Treating Physician Signature:

Date Approved:

FAX: 408-228-8401 (toll-free)
E-mail: info @allianceoccmed.com