Appointment Protocol

State Workers’ Compensation or Personal Injury

Use different forms for Federal Workers’ Compensation, VA Disability or Social Security Disability. Forms at www.EllisClinic.com or call Ellis Clinic.

Date: ____________________________

Referring Attorney: _____________________________________________________________

Address: __________________________________________________________________________

____________________________________________________________________________________

Phone ___________________________ Fax ___________________________

CLIENT’S Name: _______________________________________________________________________

Fee: $500 Payable at the time records are submitted. There may be an extra fee if there are extensive records or multiple injuries or conditions to be evaluated.

Collation of Records:

1. Legal:
   ● Claim Form
   ● Attorney correspondence
   ● Prior adjudications

2. Summary List of Records
   ● Your Summary List will be attached to the expert medical opinion report.
   ● If no Summary List the report will only reference the thickness of the records.

3. Medical:
   Send only pertinent records such as the Operation Report but not all the hospital records. Staple or clip together each operative report, test or medical provider.
   ● Operation Reports and Hospitalization Discharge Summaries
   ● Tests: MRI, EMG, X-Ray
   ● Physician Records: Staple or clip together each doctor or clinic.
   ● Other Records

4. Submit an Ellis Clinic Injury Information form for each claim.

Summary List Example

John Q. Doe, Claim# or SSN 123-45-6789
1. CC-Form 3 Filed 9/1/2016
2. Operations:
   a. 2/7/17 Left Shoulder Arthroscopy: Rotator Cuff Repair, Ima Cutter, MD
      Post Op Diagnosis: Rotator Cuff Tear
   b. 3/3/15 Lumbar Spine L5-S1 Fusion, Joe Bones, DO
      Post Op Diagnosis: Herniated Disc L5-S1
3. Tests:
   a. 6/6/14 MRI Left Shoulder
   b. 4/2/14 EMG/NCS Lower Extremities
4. Physician Records:
   a. 4/4/13 to 12/3/17, Ima Cutter, MD
   b. 8/6/13 to 7/3/17, Joe Bones, DO
5. Other Records
Injury Information: State Workers’ Compensation or Personal Injury

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Date of Injury: _________________________ Type of Injury: [ ] State Workers’ Compensation [ ] Personal Injury

Patient Name: ____________________________________________________________________________________________________________________________________________

SSN: __________________________________________________________ Date of Birth: _____________________________

❑ Male ❑ Female

Address / PO Box: ____________________________________________________________________________________________________________________________________________

City: __________________________________________________________ State: ____________ Zip: __________________________

Phones __________________________________________________________________ E-Mail ______________________________________________________

Referring Attorney: __________________________________________________________________________________________________________________________________________

BRIEFLY DESCRIBE WHAT CAUSED THIS INJURY. Examples: Slipped and fell on my back, My car was hit from the rear, A box fell on my left shoulder.

_____________________________________________________________________________________________________________________________________


_____________________________________________________________________________________________________________________________________

WHERE DO YOU STILL HAVE PROBLEMS?

_______________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________

DID YOU MISS WORK DUE TO THIS INJURY? [ ] No [ ] Yes If Yes list or estimate the dates or time missed. __________________________________________


_____________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________

Circle Where You Still Have Pain or Problems from This Injury

PERTINENT PAST MEDICAL HISTORY (Surgeries, Diseases not mentioned above)

_______________________________________________________________________________________________

PERTINENT FAMILY MEDICAL HISTORY (Asthma, Diabetes, Heart Attacks, Strokes, etc.)

_______________________________________________________________________________________________

MEDICATION ALLERGIES:

_______________________________________________________________________________________________

WORK STATUS: [ ] Still working for same employer [ ] Working for a new employer

[ ] Still off work due to this injury [ ] Fired [ ] Retired

SCHOOL: [ ] High School Degree [ ] GED [ ] Years in College or Degrees

Ellis Clinic is in the 9 story 5100 Building located to the west of the corner of NW 50th Street & N. May Ave in Oklahoma City, OK

11/19/18 Form C:\#Appointments\ProtocolWC&PI.wpd This form replaces any prior forms