TOTAL MEDICAL

(945) 221-6689
referrals@totalmedicalmd.com

Attorney Referral Form

Personal Injury Case Coordination
Letter of Protection (LOP) Referrals Accepted

Please complete all applicable fields below. Submission does not guarantee acceptance — a coordinator will confirm scheduling and coverage in writing before treatment begins.

REFERRED BY:

1. REFERRING ATTORNEY & LAW FIRM INFORMATION

ATTORNEY NAME

LAW FIRM NAME

ATTORNEY PHONE

ATTORNEY EMAIL

CASE MANAGER NAME

CASE MANAGER PHONE

CASE MANAGER EMAIL

2. CLIENT / PATIENT INFORMATION

CLIENT FULL NAME

DATE OF BIRTH

GENDER

☐ Male ☐ Female

CLIENT PHONE

CLIENT EMAIL

CLIENT ADDRESS (STREET, CITY, STATE, ZIP)

DATE OF LOSS / INCIDENT

PREFERRED CLINIC / LOCATION

TYPE OF INCIDENT

☐ Motor Vehicle Accident ☐ Commercial Vehicle ☐ Slip & Fall ☐ Workplace Injury

☐ Other: _____

BODY REGIONS / INJURIES INVOLVED

3. CASE & COVERAGE DETAILS

COVERAGE / ARRANGEMENT

☐ Letter of Protection (LOP) Policy Limit: _____

SERVICE(S) REQUESTED

☐ Discseel Evaluation ☐ IV Exosome Therapy ☐ Other: _____

PRIOR IMAGING / MEDICAL RECORDS ON FILE?

☐ Yes ☐ No IF YES, PLEASE ATTACH OR SEND SEPARATELY

4. REFERRAL NOTES

5. AUTHORIZATION

☐ I confirm that I am the referring attorney (or an authorized representative of the firm) and that I am authorized to share this referral information with Total Medical for the purpose of care coordination.

AUTHORIZED SIGNATURE

DATE

SUBMIT COMPLETED REFERRAL TO YOUR TOTAL MEDICAL COORDINATOR

Phone: (945) 221-6689 Email: referrals@totalmedicalmd.com

Do not use this form for medical emergencies. If your client requires emergency care, call 911 or direct them to the nearest emergency room.