**IME/EME and SMO Appointments**

**Patient Information**

Patient Name _____

Address _____

City, State, Zip _____

Phone Number _____ Cell Phone _____

Date of Birth _____ SSN _____

Claim Number _____

**Injury Information**

What will Dr. Gandy examine? _____Date of Injury_____

Does Dr. Gandy need to address causation at this evaluation? ____Yes _____No

Will specific questions be sent for Dr. Gandy to answer in the report? _____ Yes _____No

**Contact Information**

(Please note, the completed report will be faxed to this person at this fax number.)

Who scheduled? _____

Name of Company _____

Phone _____ Fax _____

**PLEASE NOTE IF CAUSATION IS ASKED, THE EXAM IS CONSIDERED AN IME.**

| | |
|---|---|
| IME or EME- 4th or 5th edition | |
| IME or EME- 6th edition | |
| SMO | |
| Impairment Rating- 4th or 5th | |
| Impairment Rating- 6th | |

**Upon completion of this form, please fax to 601-981-7229 for an appointment to be scheduled. Please allow 48 hours for scheduling.**

*FOR OFFICE USE ONLY*

Appointment _____

Pre-Pay Letter sent? _____ Scheduled by _____

Fee _____