FEINBERG MEDICAL GROUP

Rachel Feinberg, D.P.T

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You have requested a Functional Capacity Evaluation (FCE) for the patient below. Please fill in all the information requested and fax this form back to our office.

PATIENT INFORMATION:

Name: ______________________________ **Mr.** **Ms.** Circle One

Address: ______________________________ **Apt. #** __________

City: ____________________ **State:** ________ **Zip:** __________

Home Phone #: (   ) ______________ **Cell Phone #** (   ) ______________

SSN#: __________ **WCAB #** __________ **DOB** __________

Area Injured: __________ **Claim #** __________ **DOI:** __________

INSURANCE INFORMATION: **EMPLOYER:** ______________________

Adj. Name: ______________________________ **Mr.** **Ms.** Circle One

Insurance Co: ______________________________

Address: ______________________________ **Suite #** __________

City: ____________________ **State:** ________ **Zip:** __________

Phone #: (   ) ______________ **Ext:** ________ **Fax:** (   ) ______________

E-Mail Address: ______________________________

Interpreter Needed: **Yes** **No** **(Interpreting services are NOT arranged by our office)**
Circle One

Applicant Attorney		**Defense Attorney**	
Name:		**Name:**	
Firm:		**Firm:**	
Address:		**Address**	
City:		**City:**	
State: ________	**Zip:** ________	**State:** ________	**Zip:** ________
Phone:	( )	**Phone:**	( )
Fax:	( )	**Fax:**	( )
E-Mail Address:		**E-Mail Address:**	

Name of Doctor Recommending FCE:

Name of Person Requesting Appt: **From:** **Def. Attny** **App. Attny** **Ins. Co.**

*****INCOMPLETE FORMS WILL NOT BE PROCESSED*****