North Carolina Industrial Commission

Workers' Compensation Nurses Section Referral Form

REFERRAL SOURCE

Name	Company			_Date _/	
Address	City		_, State _	_ Zip	-
Telephone (Fax (
REASON FOR REFERR	AL/SPECIFIC CONCERNS				
INJURED EMPLOYEE					
		22.1			
Name		SS#			
Address	City		_, State _	_ Zip	-
	Telephone ()		<u> </u>		
Date of Injury / /	Type of Injury				
Physician's Name			G 4 4	77 •	
Address	City		_, State _	_ Zıp	-
Telephone () -	Fax (<u>)</u> -				
EMPLOYER					
Name					
Contact Person	Title				
Address	City		_, State	Zip	-
Telephone () -	Fax <u>) -</u>				
<u>CARRIER</u>					
Name					
Claims Representative		Claim #			
Address	City		_, State _	_ Zip	-
Telephone () -	Fax () -				
Defense Attorney		Telephone ()	<u>-</u> Fa	ax <u>()</u>	-
Plaintiff Attorney		Telephone ()	<u> </u>	ax <u>()</u>	-
ASSIGNED REHABILIT	ATION PROFESSIONAL (if in	volved)			
Name	Company				
Address	City		_, State	_Zip	-
Telephone (
				Revised	1 5/15/2012

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