North Carolina Industrial Commission

**Medical Rehabilitation Nurses Section Referral Form**

# REFERRAL SOURCE

Name Company Date / /20 Address City , State Zip - Telephone ( ) - Fax ( ) -

# REASON FOR REFERRAL/SPECIFIC CONCERNS

**INJURED EMPLOYEE**

Name IC# SS#XXX-XX-

**Address**  **City**  **, State**  **Zip - County**  **Telephone (** ) - **Fax (** ) -

Date of Injury / / Type of Injury

Physician's Name

Address City , State Zip - Telephone ( ) - Fax ( ) -

# EMPLOYER

Name

Contact Person Title Address City , State Zip - Telephone ( ) - Fax ) -

# CARRIER

Name

Claims Representative Claim # Address City , State Zip - Telephone ( ) - Fax ( ) -

Defense Attorney Telephone ( ) - Fax ( ) - Plaintiff Attorney Telephone ( ) - Fax ( ) -

ASSIGNED REHABILITATION PROFESSIONAL (if involved)

Name Company Address City , State Zip - Telephone ( ) - Fax ( ) -

PLEASE FILE VIA EDFP using “Rehabilitation Referral” document name – <https://www.ic.nc.gov/docfiling.html>

Claimants without representation may file via email to rehab.referrals@ic.nc.gov

**Rev. 4/2025**