PACBLU

Referral – Service Form

Submit Referral Via One of the Following
Fax: 808.-955.2925
Email: referrals@pacblu.com
Mail: 1357 Kapiolani Blvd, Ste 1015
Honolulu, HI 96814

Requested Specialist: _____ Date: _____

☐ Medical Case Management ☐ Vocational Rehabilitation

☐ Limited Assignment ☐ Full Field Case Management ☐ Telephonic Case Management

Task Assignment(s): Please check all that apply

☐	Attend Physician's Appointment	☐	Obtain Work Restrictions	☐	Obtain Medical Records
☐	File Review	☐	Life Care Plan	☐	Transferable Skills Analysis
☐	Labor Market Survey	☐	Transitional Work Assessment	☐	Ergonomic Assessment
☐	Job Analysis	☐	Future Care Cost Projection	☐	Other
☐	Initial Review / Assessment Only – please contact me to discuss service options				

Claim Type: Please check below

☐	Worker's Compensation	☐	General Liability	☐	Long Term Disability	☐	Auto	☐	Group Health
☐	Other (please specify)								

Insurance Carrier

Company: _____

Adjuster: _____ Phone: _____

Fax: _____ Email: _____

Claimant: Please complete or attach WC-1

Name: _____ Phone: _____

Address: _____

DOI: Claim#: _____ Occupation: _____

Primary ICD-10 code: _____

DOB: _____ SSN: xxx-xx- Claimant advised of our involvement? ☐ Yes ☐ No

Employer: Please complete or attach WC-1

Employer: _____

Contact: _____ Phone: _____

Physician Claimant Attorney

Name: _____ Name _____

Attorney advised of our involvement? ☐ Yes ☐ No

Special Instructions / Goals