PANEL OF CONSULTANTS

Panel of Consultants is the oldest and most respected medical panel provider in Washington. Our board-certified physicians represent a wide range of medical and surgical specialties. Their relationship is with Panel of Consultants, **NOT** the referring company, employer, insurer, third party administrator, or legal representative.

The examination in our offices is for evaluative purposes ***only***, to address specific injuries or conditions. Our physicians are unable, by statute, to address questions regarding your claim, your current condition, or their findings. While you will be able to obtain their report through your claim administrator, we strongly urge you to review our report with your attending physician.

Your evaluation today is NOT a substitute for a general medical examination or a visit with your attending physician.

In order to assist the physicians in the evaluation of your injury, please provide the following information:

Name: ____
Last First Middle

Birthdate: ____/____/____ **Age:** ________ **Claim Number(s):** ____________________

Current Address: ____________________________________

City: ____________________ **State:** __________ **Zip Code:** __________

Home phone: ____________________ **Cell Phone:** ____________________

Email Address: ____________________________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Have you been married more than one time? ☐ Yes ☐ No If yes, how many times: __________

Do you have any dependent **children?** ☐ Yes ☐ No Please list their gender(s) and age(s): __________

____

Other names your medical records may appear under: ____________________

Military Service: Branch: __________ Years: ______ Type of Discharge: __________

Rank at Discharge: ____________________ Do you have a service related disability? ☐ Yes ☐ No

If yes, please describe: ____________________________________

Are you receiving compensation for other injuries or disabilities (i.e., Social Security Disability)? ☐ **Yes** ☐ **No**

If yes, please explain: ____________________________________

Education: List highest education level and/or degrees attained (Example: 3 years High School **or** High School Diploma): __________

____

Vocational Training (Special Training, Apprenticeships, Certifications): ____________________

____

Please give a short description of the injury or onset of the condition we are reviewing today: __________

____

Part(s) of the body injured: ____________________________________

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What is your major problem/chief complaint today? ______________________________

____

Briefly describe the treatment you have received for the injury/condition: ______________________________

____

Are you **currently** receiving treatment? ☐ Yes ☐ No If yes, please describe: ______________________________

____

Were there **any prior injuries** to this/these area(s)? ☐ Yes ☐ No If yes, please describe: ______________________________

____

List ALL medications you are currently taking, including supplements, AND DOSAGE: ______________________________

____

Name of physician(s) treating your injury: ______________________________

List any family medical problems: ______________________________

Describe ALL previous injuries or major illnesses you have had: ______________________________

____

Please list any surgeries you have had: ______________________________

____

Review of Systems: Please indicate with a check mark in the box ☒ if you have had any of the following procedures or conditions, or problems with the any of the listed organ systems:

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Bladder	☐ Blood Pressure	☐ Cancer	☐ CRPS/RSD
☐ Depression	☐ Diabetes	☐ Heart	☐ Headache	☐ Hepatitis	☐ Kidney	☐ Liver
☐ Lungs	☐ Osteoporosis	☐ PTSD	☐ Seizures	☐ Sexual Function	☐ Skin Condition	☐ Ulcer(s)
☐ Surgeries	☐ (other) Injuries		☐ (other) Illnesses		☐ Other Conditions not listed	

Please explain, including the approximate date(s): ______________________________

____

____

Are you ☐ Right Handed or ☐ Left Handed? Height: ______’ ______” **Weight:** ______________ **lbs**

[Office Use Only ______________]

DO YOU:

Use tobacco? ☐ **Yes** ☐ **No Frequency:** ______ **per** ______ **Consume alcohol?** ☐ **Yes** ☐ **No Frequency:** ______ **per** ______

Exercise regularly? ☐ **Yes** ☐ **No Have hobbies?** ☐ **Yes** ☐ **No Describe:** ______________________________

Use recreational drugs, including cannabis? ☐ **Yes** ☐ **No Frequency:** ______ **per** ______

Drink caffeinated beverages? ☐ **Yes** ☐ **No Frequency:** ______ **per** ______

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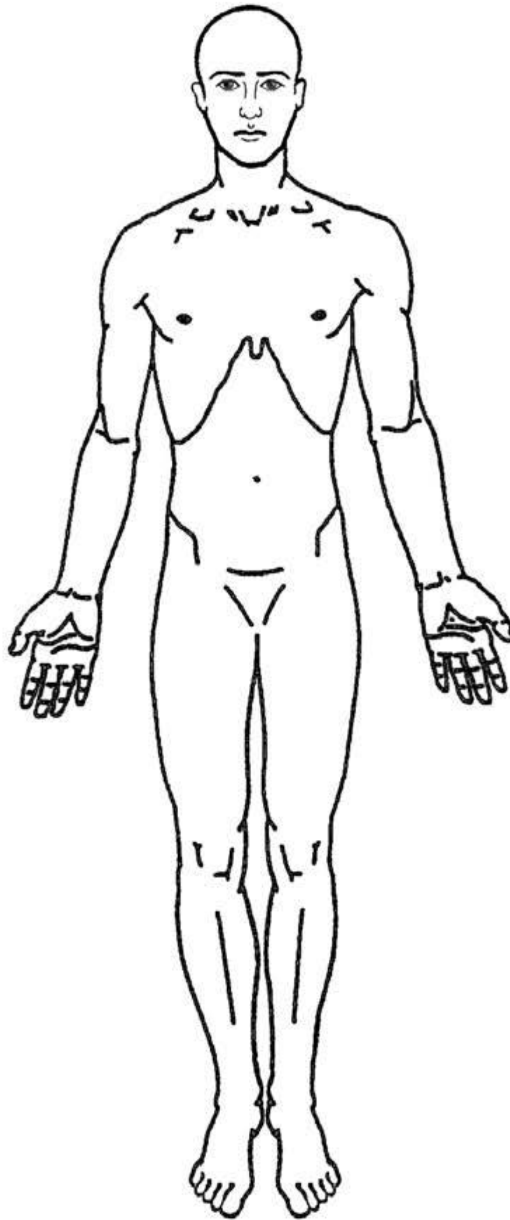
YOUR NAME: ______________________ Date: ______________

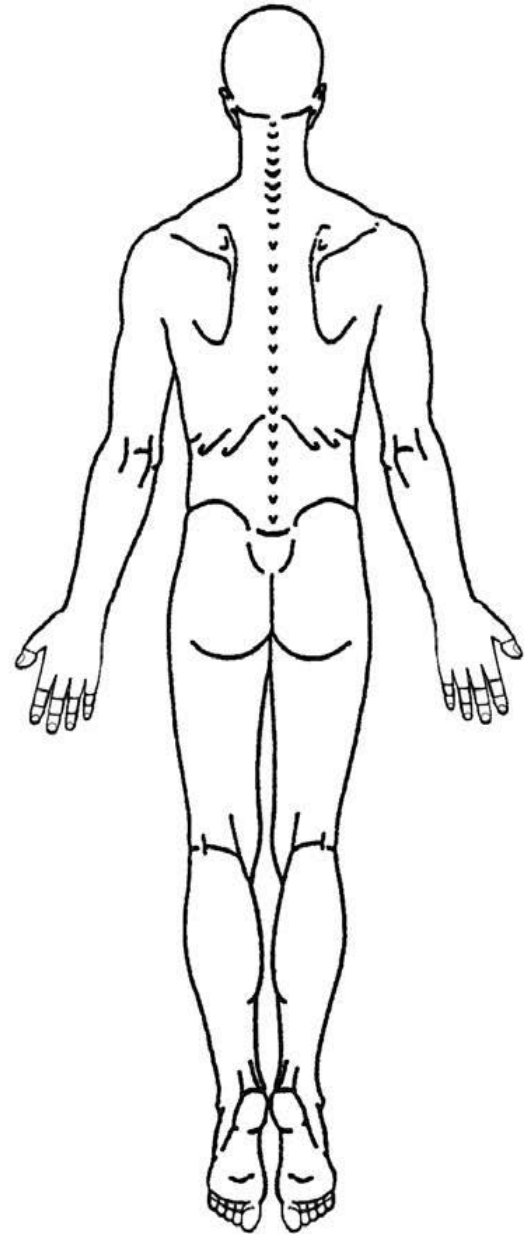
ON THE MODEL, INDICATE
YOUR ***CURRENT STATUS*** WITH
THE FOLLOWING SYMBOLS:

XXXXXXX
TO MARK
THE SITE
OF YOUR INJURY

++++++++
TO MARK
LOSS OF FEELING

00000000
TO MARK
LOCATION OF PAIN





OCCUPATIONAL DISEASE & EMPLOYMENT HISTORY (CONTINUATION)

Page of	Name (please print)	Claim Number

This is a continuation sheet. You must complete the first page of this form. If additional space is needed you may make copies of this form.

Please continue with your most RECENT job and work BACKWARDS

Employer's business name			Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity				
Indicate any break or interruption in your work history during this job or between this job and the next. From (mo/yr) To (mo/yr) Reason for interruption:				

Employer's business name			Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address			Employer's phone number	
City	State	ZIP+4	How many hours per week did you perform the activity you believe caused your symptoms? hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity				
Indicate any break or interruption in your work history during this job or between this job and the next. From (mo/yr) To (mo/yr) Reason for interruption:				

Employer's business name			Your job title	**Employment Dates:** From (mo/yr) To (mo/yr)
Employer's address			Employer's phone number	
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Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity				
Indicate any break or interruption in your work history during this job or between this job and the next. From (mo/yr) To (mo/yr) Reason for interruption:				

Dept of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

I certify that the information is true and correct to the best of my knowledge.

Date: Signature:

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CENTRAL SEATTLE · EVERETT · TACOMA

Authorization for Release of Healthcare Information

I hereby authorize use and disclosure of my health information as described below.

Patient Name:____**DOB:** ____________________

Specific description of information be disclosed: All healthcare and other patient information **related to my industrial injury claim,** both predating and within 90 days after the date of this authorization, including, but not limited to, any health history I provide, and all examination findings and testing results, including x-ray and laboratory reports. This expressly includes information regarding testing, diagnosis, and treatment for mental health, drug/ alcohol use, HIV/AIDS, and sexually transmitted diseases.

The above information may be disclosed to:

Panel of Consultants
(Central Seattle · Everett · Tacoma)
411 12th Avenue, Suite 300
Seattle, Washington 98122-5523
Phone: (206) 622-2305
Fax: 206-343-9364

The above information may be used for evaluating the undersigned patient's injuries or conditions.

This authorization is valid for 90 days from the date of signature.

1. I understand that information about my case is confidential and may be protected by federal and state law. I understand that once disclosed, this information will be re-disclosed only to those involved in the adjudication of my claim and that the information may or may not be protected under state and federal privacy regulations once so re-disclosed.
2. I may revoke this authorization at any time, in writing, to Panel of Consultants; however, I understand that such cancellation will not affect any use of information that was re-disclosed before cancellation.
3. I understand that Panel of Consultants is not providing me medical treatment, but only evaluation for a third party.
4. I understand I have access at any time to my medical records from the entity referring me today for evaluation, including information collected by Panel of Consultants.
5. I understand that I must request the information covered under this release, and the evaluation report(s) from the referring entity and not Panel of Consultants.
6. I understand what this agreement means and I am satisfied with explanations I may have requested and received.
7. I certify that I have been provided a copy of this signed authorization, if requested.

Patient Signature: ____ **Date:** _______________

OR

Patient Representative Signature: ____

Nature of Authority: ____ Date: _______________