

North Carolina:  
Ph. (704) 596-6663  
Fax (704) 597-5313

# Body Mechanics, Inc.

Texas:  
Ph. (512) 451-1668  
Fax (512) 459-8353

## FUNCTIONAL CAPACITY EVALUATION REFERRAL

### REFERRAL SOURCE

Name: \_\_\_\_\_  
Last \_\_\_\_\_ First \_\_\_\_\_

Address: \_\_\_\_\_  
Street, Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone No: \_\_\_\_\_ Email: \_\_\_\_\_

### CLAIMANT

Name: \_\_\_\_\_ M/F: \_\_\_\_\_ DOB: \_\_\_\_\_

File/SS#: \_\_\_\_\_ Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_

Address: \_\_\_\_\_  
Street, Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Interpreter: Yes/No \_\_\_\_\_ Language: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ DOI: \_\_\_\_\_

Functional Capacity Evaluation (Any Occ.)  Functional Capacity Evaluation (Own Occ.)

Return to Work Evaluation  Disability Evaluation

### PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_

Phone No: \_\_\_\_\_ Fax No.: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

### INSURANCE INFORMATION (Billing Information)

Insurance Company: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
Phone No: \_\_\_\_\_

Address: \_\_\_\_\_  
Street, Unit \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### AUTHORIZATION

I hereby acknowledge that I am authorized to assure payment will be made for services provided at my request.  
I also authorize payment in full for a client No Show or Cancellation of less than twenty-four (24) hours notice.

Name: \_\_\_\_\_ Fax No.: \_\_\_\_\_  
Phone No: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_