

Return to:

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## REPORT OF MEDICAL EVALUATION

1. Injured Patient's Name (Last, First, Middle Initial)	2. Approximate Date of Injury	3. Date of Last Visit
4. Doctor's Name, Title & Specialty		5. Phone Number:
6. Doctor's Mailing Address: (Street or P.O. Box)		(City & State) (Zip Code)
7. Professional License Number		8. Number of Visits by Patient
9. Diagnosis		10. Estimated Future Medical Treatment & Costs
<b>IMPAIRMENT RATING</b>		
11. I certify that the patient has a whole body impairment rating of _____%.		
<p>The impairment rating should be based on objective clinical or laboratory findings. Objective clinical or laboratory finding means a medical finding of impairment resulting from the above-referenced injury, based on competent objective medical evidence that is independently confirmable by a doctor, including a designated doctor, without reliance on the subjective symptoms perceived by the patient. The impairment rating shall be based on the above-referenced injury alone.</p>		
12. Additional Comments		
13. Signature of Doctor	14. Date of Report	15. Doctor Type: (Check Appropriate Blank)
_____	_____	<input type="checkbox"/> Treating <input type="checkbox"/> Other