THE CENTERS

# Medical Report Intake Form
# Product Liability

| | | |
|---|---|---|
| Law Firm:<br><br>Contact Person/Number: | | Client/Case Name:<br><br>Age: DOB: |
| Date of Injury: | Date Sent to CLS: | Deadline: |
| Brief Description of Incident and Injury: | | |
| Name of Product: | | |
| Date of Death (if applicable): | | Family/Client Diary:<br>☐ YES ☐ NO |
| Currently Treating:<br>☐ YES ☐ NO | | Permanent Injury:<br>☐ YES ☐ NO |
| Medical and Billing Records:<br>☐ HAVE ☐ NEED TO OBTAIN | | |

Healthcare Provider Information:

| | | | |
|---|---|---|---|
| Medicare: | ☐ YES | ☐ NO | |
| Medicaid: | ☐ YES | ☐ NO | |
| Private Insurance: | ☐ YES | ☐ NO | If Yes, Provider Name: _____ |
| Tri-Care/VA Coverage: | ☐ YES | ☐ NO | If Yes, Provider Name: _____ |
| Other Coverage: | ☐ YES | ☐ NO | If Yes, Provider Name: _____ |

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## Document Checklist

- ☐ Complaint
- ☐ Interrogatories
- ☐ HIPAA Form, signed and up to date

  *(only applicable for Medical Record Retrieval services)*
- ☐ Product information and/or pictures
- ☐ Hospital records/ER records
- ☐ Primary Care Physician records
- ☐ Additional treating physician records
- ☐ Medical bills from all treating facilities
- ☐ Therapy records
- ☐ Employment records for wage loss verification
- ☐ Documentation of out-of-pocket expenses
- ☐ Medical examiner evaluation report (if applicable)

## Optional Records (may be beneficial depending on case)

- ☐ Family or client diary/summary of events and discussions with healthcare providers
- ☐ Photographs of injuries (if applicable)

*Medical Records Analysis Disclosure: After review of medical records received to date, further medical record retrieval may be necessary in order to complete full medical case analysis. A summary of the records required will be forwarded for your review and retrieval will begin upon your authorization. Additional record retrieval fees will apply to amended retrieval efforts.*

**Completed By:** _____ **Date:** _____