NORTHWEST MEDICAL EXPERTS
NWMEDICALEXPERTS.COM

SERVICE REQUEST FORM

DATE:	TYPE OF REQUEST: ☐ IME ☐ RECORD REVIEW ☐ MEDICAL MALPRACTICE ☐ OTHER
	IF OTHER, DESCRIBE:

NWME has the authority to coordinate directly with opposing counsel for scheduling purposes. ☐ YES ☐ NO

REQUESTING CLIENT INFORMATION

Who do you represent: ☐ Plaintiff or ☐ Defendant or ☐ Other – If Other, please specify:

Name:	Firm:	
Phone:	Email:	Fax:
Address:		
City:	State:	ZIP Code:
Paralegal:	Email:	Phone:

INJURED PARTY AND REPRESENTATIVE INFORMATION

Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Representative Name:	Firm:	
Phone:	Email:	Fax:
Address:		
City:	State:	ZIP Code:
Paralegal:	Email:	Phone:

CASE INFORMATION

Type of Injury/Issues:		Date of Loss:
Caption:		
Cause No.:	Venue/Court:	Claim No.:
Case Type: ☐ Trial ☐ Mediation ☐ Arbitration		Event Date:
Direct Bill Adjuster: ☐ YES ☐ NO	Adjuster Name:	Adjuster Email:
Split Invoice: ☐ YES ☐ NO	Other Parties Name/Email:	

CONSULTANT AND EXAM INFORMATION

Requested Consultant and/or Specialty:		
Location of Exam:	Report Due Date:	☐ VERBAL ☐ WRITTEN
Pending Stipulation: ☐ YES ☐ NO	Order Entered: ☐ YES ☐ NO	Discovery Cutoff Date:
Testimony Requested: ☐ YES ☐ NO	Testimony Date:	

FILE / RECORDS INFORMATION

Status – Available? ☐ YES ☐ NO	If NO, when?	Estimated Size?

MISCELLANEOUS / NOTES

CONTACT US TO EXPERIENCE THE NWME DIFFERENCE!
866.276.0505 | scheduling@nwmedicalexperts.com