



PLETHY RECUPE WC REFERRAL FORM

Fax: (855) 845-1018 or email: order@plethy.com

*Please include the injured worker's last name in subject line
Attach the latest physician and/or PT/OT report with Form for old claims*

Date (MM/DD/YY) Examiner/Adjuster
Client Phone Number

INJURED WORKER INFORMATION

Name (First, Last)
Date of Birth (MM/DD/YY) Gender
Date of Injury (MM/DD/YY) Claim #
Mobile Number Email
Mailing Address
City State Zip Code
Employer Occupation
Preferred Language

Physical Demand of Occupation ☐ Sedentary ☐ Light ☐ Moderate ☐ Strenuous
Current Work Status ☐ On Medical Leave ☐ RTW, Modified Duty ☐ RTW, Full Duty
Current Work Schedule ☐ Day shift ☐ Swing shift ☐ Nights
Currently in PT/OT ☐ Y ☐ N Date of Last PT/OT Visit (MM/DD/YY)

REASON FOR ORDER

Please provide the diagnosis and/or procedure, check appropriate boxes, and fill in the blanks if applicable.

Diagnosis ☐ L ☐ R ☐ BIL
Surgical ☐ Y ☐ N Date of Surgery (MM/DD/YY)
Procedure

PROVIDER CONTACT INFORMATION

Physician's Name
Facility Phone Number
PT/OT's Name
Facility Phone Number

ADDITIONAL HEALTH INFORMATION

Comorbidities ☐ HTN ☐ Obesity ☐ Diabetes ☐ Osteoporosis ☐ Anxiety
☐ Depression ☐ Other
Comments (if applicable)