Date of Loss: _____ Type or choose a date XX/XX/XX

Claim Number: _____

LEMIEUX & ASSOCIATES
a private investigative agency

REFERRAL FORM

PLEASE EMAIL TO: cases@lemieuxassociates.com
Kindly include any Police Report with this form.

Referral Date:_____ Type or choose a date XX/XX/XX Rush: ☐ Yes ☐ No Due Date:_____ Type or choose a date XX/XX/XX ☐ Date Specific:_____ Type or choose a date XX/XX/XX

CLAIM TYPE

☐ Workers' Comp ☐ General Liability ☐ Disability ☐ Auto ☐ Other _____

SERVICES REQUESTED

☐ Surveillance ☐ Unmanned Surveillance ☐ Background Investigation ☐ Statement
☐ Medical Canvass ☐ Court Appearance ☐ Social Media Only ☐ Clinic Inspections|Surv.
☐ Locate/Skip Trace ☐ Process Service ☐ Activity Check ☐ AOE/COE
☐ Other _____

Statements/Interview: *Please check all that apply*

☐ Claimant ☐ Medical Authorization/Release
☐ Insured ☐ Site Inspections | Scene Inv.
☐ Employer ☐ Process Service
☐ Doctor ☐ Record Retrieval
☐ Witness ☐ Other

Background: *Please check all that apply*

☐ Comprehensive ☐ Skip Trace
☐ Criminal ☐ Police Report
☐ Civil ☐ Bankruptcy

INVESTIGATION INSTRUCTIONS

Number of Days: _____ **Budget:** _____

Objectives/Comments
(Please provide any additional information, attach additional pages as needed) _____

CLIENT INFORMATION

Claim Number: _____
Claim Adjuster: _____
Company: _____
Address: _____
City/State/Zip: _____
Phone: _____
Email Address: _____
TPA: _____

Insured Name: _____
Address: _____
Contact/Phone: _____
Defense Counsel: _____
Attorney Phone: _____
Attorney Address: _____
City/State/Zip: _____
Copy to Counsel? ☐ Yes ☐ No

Bill: ☐ TPA ☐ Insurance ☐ Client ☐ Other: (List Details)_____

LEMIEUX & ASSOCIATES

a private investigative agency

CLAIMANT INFORMATION

Claimant: _____ **Date of Birth:** _____

Address: _____ **SS#:** _____

City/State/Zip: _____ **Driver's Lic. #:** _____

Phone | Email: _____ **Gender:**

Description: Hgt:____ Wgt:____ Hair:_____ **Represented:** ☐ Yes ☐ No

Ethnicity: _____ **Date of Hire:** _____ Type or choose a date XX/XX/XX

Occupation: _____ **Date of Loss:** _____ Type or choose a date XX/XX/XX

Type of Injury: _____ **Injury Reported:** _____

Restrictions: _____ **Employer Info:** _____

Significant other / Known relatives: _____

Social Media Links: _____

Prior Surveillance Conducted? ☐ Yes ☐ No

Deposition Taken? ☐ Yes ☐ No

Upcoming Calendar Dates (trial, depo, IME, etc.)? _____

PHYSICIAN INFORMATION

Medical Group: _____ **Doctor:** _____

Address: _____ **Phone:** _____

City/State/Zip: _____ **Appt. Date/Time:** _____

AOE/COE ASSIGNMENT INFORMATION

Was first report of injury completed?	☐ Yes ☐ No	**If "yes", please provide copy of same**
Is Employer Contact Information available?	☐ Yes ☐ No	**If "yes, please include below**
Name: **Telephone:**		**Email:**
Were claimant's full personal identifiers provided above (address, phone #, DOB, SS#, job title, etc.?	☐ Yes ☐ No	
Is Medical paperwork/documentation available?	☐ Yes ☐ No	**If "yes" please include with referral**
Is claimant represented by an attorney?	☐ Yes ☐ No	**If "yes", please provide Notice of Representation/Application for Adjudication**
Is there an Employer's Report of Occupational Injury or Illness (From: 5020)?	☐ Yes ☐ No	**If "yes", please provide with referral**
Adjuster Case File Notes (3 Point Contact Notes)	☐ Yes ☐ No	**If "yes", please provide Case File Notes**

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