

MICHAEL L. STINSON & ASSOCIATES

Fax referral request to 512.761.4221 or email to msaaustin2@gmail.com

REFERRAL REQUEST

Date of referral: _____

Services are requested by: _____

Name/title: _____ Phone: _____ Fax: _____

Firm name: _____

Mailing address: _____ Email: _____

Client name: _____ Phone: _____ Email: _____

Mailing address: _____ Date of birth: _____

Date of accident/injury: _____ Usual occupation: _____ Employer: _____

Date last worked: _____ Approximate annual earnings: _____

Type of disability/primary diagnosis: _____ MMI/P&S? __ yes __ no

Work restrictions, if known: _____

Primary treating doctor: _____ Phone: _____ Fax: _____

Services requested (Check all that apply):

_____ Employability and
Earning Capacity Assessment

_____ Forensic Vocational Expert
Witness Testimony

_____ Wage and Labor Market
Research

_____ Vocational/Academic/Career
Testing

_____ Job Descriptions and Job Analysis
Report

_____ Rehabilitation Counseling and
Case Management

_____ Career Counseling

_____ Independent Living Evaluation

_____ Individualized Rehabilitation Plan
Development

_____ Job Placement

_____ Disability Management Consulting

_____ Vocational Evaluations

Additional Comments, Issues or Concerns:

THANK YOU. MR. STINSON WILL REVIEW YOUR REQUEST AND CONTACT YOU WITHIN 24 HOURS. YOU MAY ALSO REACH HIM AT 512.761.4488.