ELITE
INVESTIGATIONS

702-897-8473
702-270-8650 FAX

INVESTIGATION REFERRAL

Date: _____ Budget: _____ Client Claim No.: _____

CONTACT _____ **Company** _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Email _____

CLAIMANT/SUBJECT _____ ☐ Photo?

Address _____ City _____ State _____ Zip _____

Phone _____ SSN _____ DOB _____

Sex ____ Race _____ Height ____ Weight ____ Hair ____ Addl. Info _____

Occupation _____ DOI _____

Injury _____ Restrictions _____

Is Claimant Working? ____ Modified Duty? ____ Work Schedule: _____

Days Off: _____

INSURED/EMPLOYER _____

Address _____ City _____ State _____ Zip _____

Contact _____ Phone _____ May we contact? _____

TYPE OF SERVICE:

☐ Surveillance ☐ AOE/COE ☐ Subrogation ☐ Liability # of Days/Hours _____

☐ Other _____

APPOINTMENT INFORMATION:

Day/Date: _____ Time: _____ Doctor: _____ Location: _____

Special Instructions: _____

SPECIAL HANDLING INSTRUCTIONS FOR REPORT AND/OR VIDEOTAPE:

Email Report to Client? ____ Email Invoice to Client? ____ Hard copies requested? ____

Video Format: ☐ VHS ☐ CD-Rom ☐ DVD

Print Form Submit by Email