[Date]

[Doctor's Name]
[Clinic/Office Name]
[Address Line 1]
[Address Line 2]

RE: Independent Medical Examination of [Plaintiff Name]
Date of Birth: [DOB]
Date of Loss: [Date of Incident]
Claim/Case Number: [Number]

Dear Dr. [Doctor's Last Name],

This office represents the [Defendant/Plaintiff] in the above-referenced matter. Thank you for agreeing to perform an Independent Medical Examination (IME) on [Plaintiff Name] scheduled for [Date] at [Time].

To assist in your evaluation, we are enclosing the following medical records and documentation for your review:

- [Description of Records 1, e.g., Hospital Records from City General]
- [Description of Records 2, e.g., MRI Reports and Imaging]
- [Description of Records 3, e.g., Physical Therapy Progress Notes]
- [Description of Records 4, e.g., Primary Care Physician Records]

We request that you perform a comprehensive examination of the claimant and provide a detailed narrative report addressing the following issues:

1. An accurate diagnosis of any injuries sustained as a result of the [Date] incident.
2. Whether the current complaints are causally related to the incident in question.
3. The necessity and reasonableness of medical treatment received to date.
4. The claimant's current level of disability and any future treatment recommendations.
5. [Additional specific questions or instructions].

Please forward your final report and invoice to our office at your earliest convenience. Should you require any additional information prior to the examination, please contact me directly at [Phone Number].

Sincerely,

[Your Name]
[Your Title]
[Law Firm/Company Name]

Enclosures