INSTRUCTION SHEET

Please complete digitally, save and send. The 1st page 'Click to Clear' button can be used to clear this form. Blue heading information is needed for estimate requests.

Digital Instructions/Records/Images, email to:
support@dmrcollation.co.uk

Physical Instructions/Records, send to:
Unit 10-12 The Watermark Business Centre, Erme Court, Leonards Road, Ivybridge, Devon, PL21 0SZ

Click to Clear Form

Today's Date:

Your Reference:

Represented Party:

- ○ **Claimant**
- ○ **Defendant**
- ○ **Joint**
- ○ **Applicant**
- ○ **Respondent**
- ○ **Other**

Estimate Needed:

- ○ **Yes**
- ○ **No**

Instruction Type:

- ○ **New**
- ○ **Update**

Page Count of all Records:

Claim Type: (select from dropdown list)

Not Yet Selected

Liability Admitted: (select from dropdown list)

Unknown

Instruction Method: (select from dropdown lists)

Records (incl. any radiology reports):

Not Yet Selected

Radiology (images):

Not Yet Selected

Invoice Terms: (select from dropdown lists)

Rate (Hourly or Fixed Fee):

Not Yet Selected

Track Value of the Case

Unknown

Expected Turnaround Times: 20-30 Working Days

Invoice payment terms are within 30-days (unless agreed otherwise in advance)*

*If other payment terms are requested, please detail these below:

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Services Required: (select from dropdown lists)

Core Service Option: Please Select From 1 of the 4 Core Services Below

Please Select Your Core Service

Additional Services:

Hosting on the ALLDOQ Shared Workspace: (incl. any case radiology)	No
Schedule of Radiology Preparation:	No
Digital Booklet Preparation: (Consolidated bookmarked & hyperlinked pdf **)	No

***in any case, for all instructions we provide a digital copy of individual record sections (as text searchable PDFs).*

Redaction required:

- ◯ **No:**
- ◯ **Yes:** ***

Return of any Extracted Records required:

- ◯ **No:**
- ◯ **Yes:** including duplicate records

***If Yes, please select all redaction required below: Press the Ctrl button for multiple line selection

No redaction required
Third Party names (relationship information to be retained)
Third Party phone numbers/email/postal addresses (not inc. client's current address)
Third Party personal or sensitive data, i.e. employment information
Your client's home telephone number
Your client's mobile telephone number
Your client's work telephone number
Your client's email address
Your client's current postal address (please provide details in the next box)
Your client's previous postal addresses
References to previous criminal convictions (if any)

Any other redaction information / requirements:

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Injury Date / Date of Knowledge:

Main Injuries:

For example, traumatic brain injury, spinal injury, psychiatric injury, birth injury, etc.

Brief Case Background:

Record Bundle Type: Please select below all record types being provided

- ☐ **Medical (GP, Ambulance, Hospital)**
- ☐ **Rehabilitation / Private Treatment**
- ☐ **Case Management**
- ☐ **Support Worker**
- ☐ **Care Home**
- ☐ **Optician**
- ☐ **Dentist**
- ☐ **Council (Social Services / Care)**
- ☐ **Department for Work & Pensions**
- ☐ **Occupational Health**
- ☐ **Personnel / Employer**
- ☐ **Military**
- ☐ **Education**
- ☐ **Other** ➡

Record Collation and Pagination Preferences:

The standard bates numbering used supports record updates without disrupting existing pagination. Records are collated in ascending date order and duplicate records are removed. Different record types are typically returned as separately indexed/paginated bundles—for example: Medical (incl. Dental & Optician), Rehabilitation, Case Management & Care Home. Each bundle will include a separate index and use a unique page identifier. If you prefer certain record types to be combined into a single bundle or require a specific pagination format such as continuous numbering, please indicate your preferences here.

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Record Source / Provider:

Please enter here all individual record provider names for the index, i.e. the name of the case management company, private physiotherapist / consultant, general practitioner etc.

Any Specific Chronology / Record Review Instructions (if applicable):

For example, any significant information you would like us to identify or focus on in our review - in addition to our standard review.

Details of any passwords needed to access the records or radiology provided:

Name of Claimant / Applicant

Claimant Date of Birth (if applicable):

Name of Defendant / Respondent:

Your Organisation Name:

Your Organisation Address:

Main Fee Earner Name/Position:

Main Fee Earner Email Address:

Your Name / Position (if different)**:**

Your Email Address (if different)**:**

ATE/BTE Insurance Provider: