

Patient Name: _____ Date of Birth: _____

Company: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Authorized by: _____ Date: _____

Work-Related Injury/Illness	Specific Body Part: _____ - If this incident is deemed not work-related, the authorizing organization will be responsible for charges prior to written notification.
DOT	<input type="checkbox"/> Drug Screen <input type="checkbox"/> Alcohol Screen <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Witness/Observed <input type="checkbox"/> Employee to Pay
Non-DOT	<input type="checkbox"/> Drug Screen <input type="checkbox"/> Alcohol Screen <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow-up <input type="checkbox"/> Employee to Pay <input type="checkbox"/> 5-panel <input type="checkbox"/> 5-panel NO THC <input type="checkbox"/> 7-panel <input type="checkbox"/> 10-panel
Physical Exam <i>(check all that apply)</i>	<input type="checkbox"/> DOT <input type="checkbox"/> Return to Work <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Respiratory Clearance <input type="checkbox"/> Employee to pay <input type="checkbox"/> Other: _____
Immunization <i>(check all that apply)</i>	<input type="checkbox"/> Hep B <input type="checkbox"/> Flu <input type="checkbox"/> TB <input type="checkbox"/> Tdap <input type="checkbox"/> Employee to pay <input type="checkbox"/> Other: _____
Other Services <i>(check all that apply)</i>	<input type="checkbox"/> PFT <input type="checkbox"/> Audiometry <input type="checkbox"/> Fit Test <input type="checkbox"/> Other: _____ _____ _____