CLIENT COMPANY REQUEST FORM

PATIENTS INFORMATION:

Name ______ DOB ______ Phone No. ______

Address ______ City/State ______ Zip Code ______

COMPANY INFORMATION:

Company's Name ______ Contact Person ______

Address ______ City/State ______ Zip Code ______

Email Address ______ Position Title ______ Department ______

(_____)______ Phone Number (_____)______ Fax Number (_____)______ Mobile Number

INSURANCE INFORMATION:

Insurance Policy No. ______ Primary Medical Carrier ______

SERVICES REQUESTED:

Employee Health, Wellness & Medical Surveillance

☐ Employee Health & Clinical Dependency Services ☐ EAP Coordination

Physical Examinations

☐ Post Offer Physical Examination with Report ☐ DOT/PUC Physical Examination with Report

☐ Crane & Hoist Physical Examination with Report ☐ Respirator Clearance with Pulmonary Function Test Screening with report

Immunizations

☐ Flu Serum ☐ Hepatitis A Vaccine ☐ Hepatitis B Vaccine ☐ Tetanus shot ☐ Gamma Globulin ☐ Tuberculosis

Diagnositcs

☐ Audio (In House) ☐ Vision ☐ Pulmonary Function Test

☐ X-Ray, Chest (1 View) ☐ X-Ray, L-Spine (1 View) ☐ X-Ray, 2 Views (Chest)

WC Injury & Risk Management

☐ First-aid Cost Containment Program ☐ 24 Hour Emergency Protocol ☐ Chart Review Consultation

☐ Back-to-Work Evaluation, Clearance & Report ☐ Workplace Walk-Through Consultation ☐ Light Duty/Back-to-Work Program

Substance Screening (Reason for Test)

☐ Pre-Employment ☐ Post-Accident ☐ Random ☐ Quick Tox Drug Screen Dip (12 Panel)

☐ Blood Alcohol (ETOH Legal) ☐ NON-NIDA ☐ NIDA

Special Instructions: ______

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