

WorkHealth

Occupational Medical Center

Employee Name: _____ Job Title: _____

Employer: _____

<p>Work-related</p> <p><input type="checkbox"/> Injury</p> <p><input type="checkbox"/> Illness</p> <p>Substance Abuse Drug Program</p> <p>Type:</p> <p><input type="checkbox"/> DOT</p> <p><input type="checkbox"/> Non-DOT</p> <p>Reason:</p> <p><input type="checkbox"/> Post offer/Pre-Hire</p> <p><input type="checkbox"/> Post Injury</p> <p><input type="checkbox"/> Post Accident</p> <p><input type="checkbox"/> Reasonable Cause</p> <p><input type="checkbox"/> Random</p> <p><input type="checkbox"/> Periodic</p> <p><input type="checkbox"/> Follow</p> <p><input type="checkbox"/> Evidential Breath Test (Breath / Alcohol)</p>	<p>Physical Exam</p> <p><input type="checkbox"/> Post Offer / Pre-Hire</p> <p><input type="checkbox"/> Department of Transportation (Initial / Recert)</p> <p><input type="checkbox"/> Department of Education (Initial / Recert)</p> <p><input type="checkbox"/> Return to Work</p> <p><input type="checkbox"/> Baseline Hazardous Materials</p> <p>Other</p> <p><input type="checkbox"/> Audiogram</p> <p><input type="checkbox"/> Back Evaluation</p> <p><input type="checkbox"/> Chest X-Ray</p> <p><input type="checkbox"/> EKG</p> <p><input type="checkbox"/> Material Handling Capacity Test</p> <p><input type="checkbox"/> Hepatitis B Vaccine</p> <p><input type="checkbox"/> Hepatitis B Antibody Titre</p> <p><input type="checkbox"/> PPD (TB test)</p> <p><input type="checkbox"/> Pulmonary Function Test (PFT)</p> <p><input type="checkbox"/> Respiratory Evaluation</p> <p><input type="checkbox"/> Tetanus</p> <p><input type="checkbox"/> _____</p>
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Special Instructions:

Follow regular protocol for specified job description

Authorized by: _____ (Signature) _____ (Please Print)

Phone: (_____) _____ Date: _____

Consent for Release of Information:

I hereby authorize WorkHealth Occupational Medical Center, its practitioners and staff, to release any information pertinent to this specific injury/illness and/or physical examination and/or drug or alcohol screen results to my Employer, Prospective Employer, Employer's Medical Review Officer, or Third Party Administrator. In addition, I hereby release WorkHealth Occupational Medical Center, its practitioners and staff, from any and all claims of actions resulting from the disclosure of these results.

I hereby give consent to WorkHealth Occupational Medical Center, its practitioners and staff, for examination and treatment.

Employee/Patient Signature _____ Date _____

****Picture ID is required for all substance abuse testing/drug screening.**

****Please do not bring children to the clinic, We cannot be responsible for them.**