RESET FORM PRINT FORM

WORKSITE MEDICAL | Occupational Health in Motion

Date:
Time of Physical:

Request for Services

ID is required at time of service

PATIENT NAME:_____ DOB: _____

EMPLOYER: _____

WORK RELATED:

Date of Injury:_____
Time of Injury: _____

DOT PHYSICAL EXAM

□ Pre-Placement
□ Recertification

SUBSTANCE ABUSE TESTING:

□ Regulated (DOT) Drug Screen
□ Non-Regulated Drug Screen
□ Breath Alcohol □ Non-DOT or □ DOT
□ Instant Rapid 10 panel Drug Screen
□ Hair Drug Screen
□ UDS Collect (must provide CCF)

PHYSICAL EXAMINATION

□ Pre-Placement
□ Asbestos
□ Respiratory
□ Fitness for Duty
□ Hazmat
□ Other: _____

REASON FOR TESTING:

□ Pre-Placement □ RTW
□ Random □ Return to Duty
□ Post-Accident
□ Follow-up
□ Reasonable Suspicion

Special Instructions:_____
_____

REQUESTING TESTING:

□ Audiogram
□ Spirometry (PFT)
□ Respirator Fit Test
□ Qualitative or □ Quantitative
□ Vaccine: _____

□ Labwork: _____
□ Lift test

BILLING:

□ Bill my company □ Employee to pay at the time of service

***** Due to the nature of our practice, only patient and staff are authorized in the treatment area *****

Authorized by: _____ _____
Please print Signature

Phone: _____ Date: _____

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