



# OCCUPATIONAL HEALTH & WELLNESS CENTER

600 Wilson Creek Road, Lawrenceburg, IN 47025 - GROUND LEVEL

730am-5:00pm

812-537-8323 Phone

Please FAX this form to: 812-537-8343 or

employee may present to Occupational Health & Wellness Center

**AUTHORIZATION FOR SERVICES**

Company Name: \_\_\_\_\_ Secure Fax \_\_\_\_\_

Employee Name: \_\_\_\_\_ Address: \_\_\_\_\_

Employee Phone: \_\_\_\_\_ (Cell) \_\_\_\_\_ (Home) DOB: \_\_\_\_\_

### PHYSICALS

<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Hazmat
<input type="checkbox"/> DOT Physical	<input type="checkbox"/> Respiratory Clearance
<input type="checkbox"/> Return to Work/Follow up after Injury	<input type="checkbox"/> Fire/Police

### VACCINATIONS

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Flu	<input type="checkbox"/> MMR
<input type="checkbox"/> Tetanus (Tdap, Td)	<input type="checkbox"/> Varicella
<input type="checkbox"/> TB Skin Test	

### DRUG & ALCOHOL TESTING

*Please select one from each of the 4 sections below:*

1.  Pre-placement  Random  Post-Accident  Reasonable Suspicion
2.  DOT or  NON-DOT (DOT=Department of Transportation/Drivers)
3.  COLLECTION ONLY  DCH-5 PANEL  DCH-10 PANEL  DAY CARE DRUG SCREEN
4.  Breath Alcohol Test  YES or  NO

### TESTING

<input type="checkbox"/> Audiogram or <input type="checkbox"/> Whisper Test	<input type="checkbox"/> PFT
<input type="checkbox"/> Functional Capacity Exam	<input type="checkbox"/> EKG
<input type="checkbox"/> Chest X Ray <input type="checkbox"/> One View <input type="checkbox"/> Two View	<input type="checkbox"/> Respiratory Fit Test
<input type="checkbox"/> Vision Exam <input type="checkbox"/> Titmus or <input type="checkbox"/> Snellen	<input type="checkbox"/> Physical Therapy

### LAB TESTING

<input type="checkbox"/> CBC	<input type="checkbox"/> MMR Titer
<input type="checkbox"/> Lipid Profile	<input type="checkbox"/> Varicella Titer
<input type="checkbox"/> Lead (blood) Chemistry	<input type="checkbox"/> Hepatitis B Titer
<input type="checkbox"/> Urinalysis	<input type="checkbox"/> A1C

### INJURY

Minor Injuries are treated in Occupational Health- Ground Floor  
To ensure accurate billing and timely service, please complete the following:

Nature of Injury \_\_\_\_\_

Date/Time of Injury \_\_\_\_\_

Bill to \_\_\_\_\_

Billing Address \_\_\_\_\_

Billing Phone \_\_\_\_\_

*\*\*Please call 8323 with claim number or write here* \_\_\_\_\_

Company authorization for treatment and billing/payment:

Company Signature \_\_\_\_\_

Date \_\_\_\_\_ Phone \_\_\_\_\_

*Company is billed for all services unless noted above. Payment is due within 60 days of service.*

*This form can be found on the Occupational Health & Wellness page of the dch.org website.*