



OCCUPATIONAL HEALTH & WELLNESS

600 Wilson Creek Road, Lawrenceburg, IN 47025 – (GROUND LEVEL)

Phone: 812-537-8323 | Hours: 7:30 am - 4:00 pm

Please FAX this form to: 812-537-8343 or employee may present upon arrival

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 (Td, Tdap)	<input type="checkbox"/> Varicella
<input type="checkbox"/> TB Skin Test	

DRUG & ALCOHOL TESTING

Please select one from each of the 4 sections below except may choose two from line 3.

- REASON FOR TEST:** Pre-placement Random Post-Accident Reasonable Suspicion
- DOT OR NONDOT:** DOT or NON-DOT (DOT=Department of Transportation/Drivers)
- TEST REQUEST:** COLLECTION ONLY RAPID-5 PANEL RAPID-10 PANEL DAY CARE SCREEN
 Check box if requesting 2 NON-DOT tests on same specimen (collection specimen sent out **AND** a second rapid test)
- 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 as applicable in Occupational Health
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 enter 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.

AUTHORIZATION FOR SERVICES