

Visit ID _____



Occ Med Intake Form

A copy of this form must accompany employee to test site.

Last Name:		Middle Initial:	First Name:
Date of Birth:	SSN:		Email Address:
Mailing Address:			Phone Number:

-Services to be provided? Please select what services need to be performed for TODAY's visit-

Drug Screens	Physicals
<input type="checkbox"/> 5 panel DOT drug screen- [OMDOTDRUG] Mode of transportation: _____ Reason for testing: _____ <input type="checkbox"/> 5 panel NON-DOT drug screen- [OM5PANEL] <input type="checkbox"/> 10 panel drug screen- [OM10PANEL] <input type="checkbox"/> 7 panel drug screen + alcohol- [OMURINEDRUG+ALCOHOL] <input type="checkbox"/> Synthetic marijuana/bath salts – [OMSYNTHETICMARIJUANA] <input type="checkbox"/> 14 panel send out drug screen- [OM14PANEL] <input type="checkbox"/> 14 panel rapid drug screen- [OMG0434] <input type="checkbox"/> Confirmation of rapid non-negative drug screen – [OMRAPIDCONFIRMATION] <input type="checkbox"/> Collection only drug screen – [OMCOLLECTONLY] Lab: _____ Panel/Type of test: _____ <input type="checkbox"/> Direct observation of urine collection – [OMDIRECTOBSERVE]	<input type="checkbox"/> DOT physical – [OMPEDOT] <input type="checkbox"/> Work physical- MainStreet form – [OMPEWORK] <input type="checkbox"/> Work physical- employer form- [OMPEWORK] <input type="checkbox"/> Fit for duty physical – [OMFITFORDUTY]
	Breath Alcohol Tests
	<input type="checkbox"/> DOT breath alcohol test (BAT) – [OMDOTBAT] <input type="checkbox"/> NON-DOT breath alcohol test (BAT) – [OMBAT]

Other Testing	
<input type="checkbox"/> Pulmonary function test (PFT) – [OMPFT] <input type="checkbox"/> Respirator fit test questionnaire – [OMRFTQUESTION] <input type="checkbox"/> Qualitative respirator fit test – [OMRFT] <input type="checkbox"/> Audiogram- Autotest – [OMAG.AUTO] <input type="checkbox"/> Audiogram- Threshold test – [OMAG.THRESHOLD] <input type="checkbox"/> Lift test – [OMLIFTTEST] <input type="checkbox"/> Snellan vision test – [OMSVT] <input type="checkbox"/> Ishahara color vision test – [OMCVTI] <input type="checkbox"/> X-ray Lumbar 3 view – [OM72100] <input type="checkbox"/> X-ray chest 2 view – [OM71020] <input type="checkbox"/> X-ray chest- B read – [OMBREAD] <input type="checkbox"/> TD- tetanus – [OM90714]	<input type="checkbox"/> Urine cobalt test – [OMCOBALT] <input type="checkbox"/> Urine nickel test – [OMNICKEL] <input type="checkbox"/> Blood draw - lead – [OMLEAD] <input type="checkbox"/> Blood draw - zinc- [OMZINC] <input type="checkbox"/> Blood draw - iron- [OMIRON] <input type="checkbox"/> Blood draw - magnesium – [OMMAGNESIUM] <input type="checkbox"/> Hep B titer – [OMHEPB TITER] <input type="checkbox"/> Hep B vaccine – [OM90746] <input type="checkbox"/> Tb skin test – [OM86580] <input type="checkbox"/> 2 step TB skin test – [OM86580] <input type="checkbox"/> Quantiferon gold TB test – [OMQUANTIFERON-TBGOLD] <input type="checkbox"/> Flu shot – [OM90656]

Who will be paying for today's services? Company/Employer Third Party Administrator(TPA) Other: _____

Employer Representative Name: _____

Employer Representative Signature: X _____

Contact for Results:	Contact for Results Phone Number:	Contact for Results Fax:	Contact for Results Email:
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Company/Employer Name:		Company/Employer Billing Address:	
Billing Contact Name:	Billing Contact Phone Number:	Billing Fax Number:	Billing Email:
TPA Name:		TPA Billing Address:	
TPA Contact Name:	TPA Contact Phone Number:	TPA Contact Fax:	TPA Contact Email:

Privacy, Billing, and Other Important Information

I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to contact me or my employers at the number listed above and leave a voicemail if I am unavailable. I have read and reviewed Rural Urgent Care LLC/MainStreet Family Urgent Care's Billing Policies and Privacy Policy. In the event of non-payment you will be responsible for the charges incurred today. I authorize release of any information concerning my health care and treatment for the purpose of evaluating and administering claims of insurance benefit. Furthermore, I authorize release of any information concerning today's visit to my employer. I consent to care and treatment of myself by the attending provider and his/her associates and assistants.

X _____ Date: _____
 (Signature of patient or parent/guardian of minor)