Visit ID _____

MainStreet FAMILY URGENT CARE

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

☐ 9 panel DOT drug screen- [OMDOTDRUG]
Mode of transportation: _____
Reason for testing: Pre-Employment
☐ 5 panel drug screen- [OM5PANEL]
☐ 10 panel drug screen- [OM10PANEL]
☐ 7 panel drug screen + alcohol- [OMURINEDRUG+ALCOHOL]
☐ Synthetic marijuana/bath salts – [OMSYNTHETICMARIJUANA]
☐ 14 panel send out drug screen- [OM14PANEL]
☐ 14 panel rapid drug screen- [OMG0434]
☐ Confirmation of rapid non-negative drug screen – [OMRAPIDCONFIRMATION]
☐ Collection only drug screen – [OMCOLLECTONLY]
Lab: _____
Panel/Type of test: _____
☐ Direct Observation of Urine Collection – [OMDIRECTOBSERVE]

Physicals

☐ DOT physical – [OMPEDOT]
☐ Work physical- MainStreet form – [OMPEWORK]
☐ Work physical- employer form- [OMPEWORK]
☐ Fit for duty physical – [OMFITFORDUTY]

Breath Alcohol Tests

☐ DOT breath alcohol test (BAT) – [OMDOTBAT]
☐ NON-DOT breath alcohol test (BAT) – [OMBAT]

Other Testing

☐ Pulmonary function test (PFT) – [OMPFT]
☐ Respirator fit test questionnaire – [OMRFTQUESTION]
☐ Qualitative respirator fit test – [OMRFT]
☐ Audiogram- Autotest – [OMAG.AUTO]
☐ Audiogram- Threshold test – [OMAG.THRESHOLD]
☐ Lift test – [OMLIFTTEST]
☐ Snellan vision test – [OMSVT]
☐ Ishahara color vision test – [OMCVTI]
☐ X-ray Lumbar 2 view –[OM72100]
☐ X-ray chest 2 view – [OM71020]
☐ X-ray chest- B read – [OMBREAD]
☐ TD- tetanus – [OM90714]
☐ EKG – [93010]
☐ Flu shot – [OM90656]
☐ Urine cobalt test – [OMCOBALT]
☐ Urine nickel test – [OMNICKEL]
☐ Blood draw - lead – [OMLEAD]
☐ Blood draw - zinc- [OMZINC]
☐ Blood draw - iron- [OMIRON]
☐ Blood draw - magnesium – [OMMAGNESIUM]
☐ Hep B titer – [OMHEPBTITER]
☐ Hep B vaccine – [OM90746]
☐ Tb skin test – [OM86580]
☐ 2 step TB skin test – [OM86580]
☐ CMP – [OMCMP]
☐ Lipid Profile – [OM80061]
☐ Thyroid Panel –[OM000620]
☐ CBC w/ Differential– [OMCBC]
☐ MMR Titer – [OMMMRTITER]
☐ BBP Post Exposure Baseline
  ☐ HIV – [OM083935]
  ☐ HepB HBsAg – [OM006150]
  ☐ HepB HBsAb – [OM006350]
  ☐ HepC HCAb- [OM140659]
  ☐ ALT - [OM001545]
☐ BBP Post Exposure 6 Weeks
  ☐ HIV – [OM083935]
  ☐ HCV RNA – [OM550090]
☐ BBP Post Exposure 3 Months
  ☐ HIV – [OM083935]
☐ BBP Post Exposure 6 Months
  ☐ HIV – [OM083935]
  ☐ HepB HBsAg – [OM006150]
  ☐ ALT - [OM001545]

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:

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 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)