Visit ID ____________

Work Comp Intake Form

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

Employee Last Name:	**Employee Middle Initial:**	**Employee First Name:**

Employee Date of Birth:	**Employee SSN:**	**Employee Email Address:**

Employee Mailing Address:	**Employee Phone Number:**

Chief Complaint:	**Date of Injury:**	**Claim Number:**

Have you been treated previously for your injury? ☐ Yes ☐ No	**If yes, when and where was your last date of treatment?**

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

Evaluation

☐ Provider Evaluation of Work Comp Injury/work-related injury

Breath Alcohol Tests

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

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

Drug Screens

☐ 9 panel DOT drug screen – [OMDOTDRUG]
Mode of transportation: ______________________
Reason for Testing: _________________
☐ 5 panel drug screen – [OM5PANEL]
☐ 10 panel drug screen – [OM10PANEL]
☐ 7 panel drug screen + alcohol – [OMURINEDRUG+ALCOHOL]
☐ synthetic marijuana/bath salts drug screen – [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]

BBP Post Exposure Testing

☐ 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 ☐ Work Comp Insurance ☐ Third Party Administrator (TPA) ☐ Other:

Employer Representative Name:

Employer Representative Signature: X____

Contact for Results Name:	**Contact for Results Phone Number:**	**Contact for Results Fax:**	**Contact for Results Email:**

Company/Employer Name:		**Company/Employer Billing Address:**	
Billing Contact Name:	**Billing Phone Number:**	**Billing Fax Number:**	**Billing Email:**
Work Comp Carrier Name:		**Work Comp Carrier Billing Address:**	
Claims Adjuster Name:	**Claims Adjuster Phone Number:**	**Claims Adjuster Fax:**	**Claims Adjuster Email:**

Privacy, Billing, and Other Important Information

I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to contact me 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. We will file a claim with your employer's insurance company for the services provided. 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 pertaining to 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)