1275 S. State Street, Dover, DE 19901
phone (302) 678-1303 fax (302)736-4332

800 N. DuPont Blvd, Milford, DE 19963
phone (302) 430-5705 fax (302)430-5679

632 Mulberry St, Milton, DE 19968
phone (302) 684-3812 fax (302) 684-2012

Patient Label

EMPLOYER AUTHORIZATION

Date: (*expires in 30 days*)
Company: _____
Address: _____
_____
_____
Phone: (____) _____
Fax: (____) _____

Appointment: ☐ Yes ☐ No
Appointment Date:_____
Appointment Time:_____ AM/PM

Authorized by: _____

Employee: _____
Address:_____
_____
Phone: (____) _____
DOB:_____
SS#:_____-_____-_____
Job Title:_____

SERVICES TO INCLUDE: (*Check all that apply*)

Workmans Comp Injuries: WC Carrier_____ **Claim#**_____ **Date of Injury** _____

☐ Treatment for Occupational Injury ☐ Treatment for Blood/Body Fluid Exposure Injury Reported:_____

Physicals:
☐ Pre-placement
☐ Annual/Periodic
☐ OSHA Medical Surveillance for:_____
☐ Asbestos Questionnaire with Physical
☐ School Bus Addendum
☐ School Bus Phys
☐ DOT Physical
☐ DOT 90day F/U
☐ College Physical
☐ School/Sport Phys

Respirator Evaluations: (Focus exam – HENT&Chest)
☐ OSHA Questionnaire Review Only
☐ OSHA Questionnaire with PFT (no exam)
☐ OSHA Questionnaire with PFT (with Focus exam)
☐ OSHA Questionnaire with Fit Test
☐ OSHA Questionnaire with PFT & Fit Test (no exam)
☐ OSHA Questionnaire with PFT & Fit Test (w/ Focus exam)

Fitness Determination:
☐ Fit for Duty ☐ Return to Work

Functional Assessment:
☐ Back Evaluation ☐ Lift Test

Drug Screening: ☐ DOT urine drug screening ☐ NON-DOT urine drug screening ☐ Hair Collection
Reason: ☐ Random ☐ Pre-employment ☐ Reasonable Suspicion/Cause ☐ Post Accident
Type: ☐ Collection and MRO ☐ Collection Only
Panel: ☐ 5 Panel (urine) ☐ 10 Panel + OXY (urine)

Breath Alcohol Testing: ☐ DOT BAT ☐ NON-DOT BAT
Reason: ☐ Random ☐ Pre-employment ☐ Reasonable Suspicion/Cause ☐ Post Accident

Additional Testing/Procedures:
☐ EKG ☐ Chest X-ray (if + PPD history) ***indicate***: ☐ 1 view (PA) ☐ 2 view (PA/LAT) ☐ Immunization Review
☐ PFT ☐ PPD (Tuberculin Skin Test) and TB Screening Vision (***select***) ☐ Titmus ☐ Snellen
☐ Audiogram (handheld) ☐ Audiogram (booth): (***select***) ☐ Conservation ☐ non-Conservation

Vaccines:
☐ Hepatitis A vaccine ☐ Hepatitis B Vaccine ☐ Tetanus Diphtheria (*Td booster*) ☐ Rabies Vaccine
☐ Other vaccine:_____ ☐ Tetanus Diphtheria Pertussis (*Tdap*) ☐ TwinRix (Hep A/B)

Lab Testing:
☐ Complete Metabolic Panel ☐ CBC with diff ☐ Lyme Titer ☐ Lipid Panel
☐ PSA ☐ Hepatitis C Antibody ☐ ALT ☐ HIV
☐ Hepatitis B Antibody Quant ☐ Urinalysis (*UA*) ☐ T-SPOT TB Blood Draw and TB Screening
☐ Heavy Metals: (specify)_____

Diagnostic Imaging:
☐ 1 View Chest X-Ray ☐ 2 View Chest X-Ray (*PA /LAT)* ☐ B-Reading w/ _____view(s) Chest X-Ray ☐ Lumbar-Sacral X-Ray (*3-views*)

Occupational Health only:

Clinical Staff Signature: _____ Date: _____ Time: _____

Provider Signature:_____ Date: _____ Time:_____