

Occupational Medicine Services Request form

EXPRESS CARE OF TAMPA BAY, INC.

Pre Employment Services

(Check mark all that is needed)

Immunizations / Shots

<p>Panel #5 Drug Test <input type="checkbox"/></p> <p>Panel # 8 D rug Test: <input type="checkbox"/></p> <p>Panel #10 Drug Test <input type="checkbox"/></p> <p>Antibody test for Hep B <input type="checkbox"/></p> <p>Audiogram <input type="checkbox"/></p> <p>Blood Borne Pathogen <input type="checkbox"/></p> <p>Breath Alcohol Test <input type="checkbox"/></p> <p>Chest X-Ray <input type="checkbox"/></p> <p>NIDA/DOT #5 Drug Test <input type="checkbox"/></p> <p>DOT Physical Exam <input type="checkbox"/></p> <p>MISC : _____</p>	<p>Hep. A vaccination <input type="checkbox"/> (2 dose)</p> <p>Hep B vaccination <input type="checkbox"/> (3 dose)</p> <p>MMR shot <input type="checkbox"/></p> <p>Tetanus shot <input type="checkbox"/></p> <p>TB skin test <input type="checkbox"/></p> <p>Flu Vaccination <input type="checkbox"/></p> <p>Varicella vaccine (chickenpox) <input type="checkbox"/></p>
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Occupation related Physical Exams (CHECK MARK REQUESTED SERVICES)

<p>Pre-Placement Physical exam <input type="checkbox"/></p> <p>OSHA /Respirator clearance Exam <input type="checkbox"/></p> <p>Scuba diving Exam <input type="checkbox"/></p> <p>Blood lead Testing <input type="checkbox"/></p> <p>Audio testing (hearing) <input type="checkbox"/></p>	<p>Vision Testing <input type="checkbox"/></p> <p>Spirometry (PFT) <input type="checkbox"/></p> <p>Health Risk assessment <input type="checkbox"/></p> <p>Back Functional assessment <input type="checkbox"/></p> <p>MISC : _____</p>
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Work related Injury treatment:

This is Work comp initial visit* *Please provide 1st Notice of injury with the employee/patient.

Drug Test required Drug Test not required Bill Company Bill insurance carrier

This is a Work Comp follow up from ER Please provide Hospital records with your visit to save time

This is a Work comp follow up visits

NOTE : WE NEED THE ABOVE WORK COMP INFORMATION ONLY ON THE FIRST VISIT.

Note to Employers: Please select the appropriate services requested above. Please sign and date this authorization

form and send or fax it to us prior to patients arrival at the clinic.

Today's Date; _____ Authorized By: _____ Signature: _____

Company's Name; _____ Billing address : _____ City: _____ St: _____

Telephone # _____ Fax # _____ Insurance carrier info: _____

Address _____

Policy # _____ Phone # _____ Case Manager: _____

Fax it to: **EXPRESS CARE at 813-645-3816 Apollo Beach**

OR **EXPRESS CARE at 813- _____ BRANDON**