URGENT CARE SOUTH

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	**Drug Screens**	Breath Alcohol Tests
☐ Provider evaluation of work comp injury/work-related injury	☐ 11 panel DOT drug screen – ☐ 11 panel NON-DOT drug screen – ☐ 11 panel send out drug screen – ☐ 11 panel in house drug screen- ☐ Collection only drug screen – Lab: _____ Panel/Type of test: _____ ☐ Direct observation of urine collection –	☐ DOT breath alcohol test ☐ Non-Dot breath alcohol test

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 and Billing Information

I authorize Urgent Care South to contact me at the number listed above and leave a voicemail if I am unavailable. I have read and reviewed Urgent Care South'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)

Urgent Care South
OCC MED INTAKE FORM

Today's Date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First:		Middle:	Marital status:		
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address: [Address/ P.O Box, City, ST ZIP Code]					
Social Security:	Home phone no.:		Cell phone:		
Occupation:	Employer:		Employer phone:		

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

Drug Screens Physicals

o 5 panel DOT drug screen-
Mode of transportation: _____
Reason for testing: _____
o 5 panel NON-DOT drug screen-
o 10 panel drug screen-
o 7 panel drug screen + alcohol-
o Synthetic marijuana/bath salts –
o 14 panel send out drug screen-
o 14 panel rapid drug screen-
o Confirmation of rapid non-negative drug screen –

Collection only drug screen _____
Lab: _____
Panel/Type of test _____

Direct observation of urine collection_____

o DOT physical –
o Work physical
o Qualitative respirator fit test –
o Pulmonary Function Test PFT

Snellan vision test
Ishahara color vision test

o X-ray Lumbar 3 view –	Flu Shot	Blood draw - Lead
o X-ray chest 2 view –	TB Skin Test	Blood draw - Zinc
o X-ray chest- B read –	Hep B titer	Blood draw - Iron
o TD- tetanus –	Hep B Vaccine	Blood draw - Magnesium

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

Employer Representative Name: **Employer Representative Signature:**

Contact for Results: **Phone number:** **Email:**

Company/Employer Name: **Billing Address:**

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X_____ Date: _____

(Signature of patient or parent/guardian of minor)