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

301 Jefferson Avenue, 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#:__________-________-_________

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
☐ DOT Physical
☐ Lift Test
☐ Back Evaluation
☐ Asbestos Questionnaire with Physical

Respirator Evaluations:

☐ OSHA Questionnaire Review Only
☐ OSHA Questionnaire with PFT
☐ OSHA Questionnaire with Fit Test
☐ OSHA Questionnaire with PFT and Fit Test

Fitness Determination:

☐ Return to Work
☐ Fit for Duty

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:

☐ Audiogram (handheld) ☐ Audiogram (booth) ☐ PPD (Tuberculin Skin Test) ☐ EKG ☐ PFT

☐ Vision w/ Titmus ☐ Vision w/o Titmus ☐ Chest X-Ray (*if + PPD history*) **indicate**: ☐ 1 view ☐ 2 view

Vaccines:

☐ Hepatitis B Vaccine ☐ Tetanus Vaccine (*Tdap*) ☐ Tetanus Vaccine (*Td booster*) ☐ Rabies Vaccine

☐ Other vaccine:____ ☐ Hepatitis A vaccine ☐ 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 ☐ ______________

☐ Heavy Metals: (specify)____

Diagnostic Imaging:

☐ 1 View Chest X-Ray ☐ 2 View Chest X-Ray (*PA /Lat*) ☐ B-Reading w Chest X-Ray ☐ Lumbar-Sacral X-Ray (*3-views*)

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Occupational Health only:

Clinical Staff Signature:____ Date: _________ Time:________
Provider Signature:____ Date: _________ Time:________