UNIVERSAL URGENT CARE OCCUPATIONAL MEDICINE

PATIENT REFERRAL

Date: ____/____/____ Expires: _____ @ ____ : ____ am / pm

Donor Name: _____

Occupation: _____

Employer: _____

Treat Injury / Illness: ☐Yes ☐No If yes, DOI: _____/_____/_____

Drug Screening: ☐Yes ☐No

If yes: ☐Rapid screen ☐Non-DOT ☐DOT

Reason: ☐ Pre-Emp ☐ Post Injury ☐ Post accident
☐ Reasonable Suspicion / For Cause ☐ Random
☐Other: _____

Breath Alcohol Testing (BAT): ☐Yes ☐No If yes, ☐DOT ☐Non-DOT

Reason: ☐ Post Injury ☐ Post accident
☐ Reasonable Suspicion / For Cause ☐ Random

Physical: ☐Yes ☐No If yes: ☐Pre-Emp ☐DOT ☐DOT Recert
☐FFD / RTW ☐Other: _____

Additional Testing: ☐Yes ☐No If yes:☐TB ☐Audio ☐Lift Test
☐Spirometry ☐Other: _____

Reporting Results: ☐Follow protocol ☐Other: _____

Comments: _____
_____
_____
_____

Authorized by: _____

Phone: _____ x _____ Fax: _____

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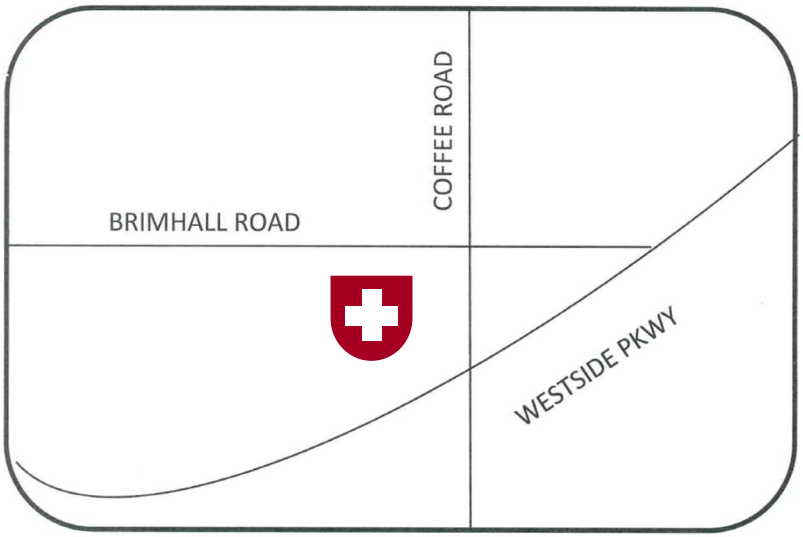

Office Hours:

Monday - Friday
8AM to 5PM