

OCCUPATIONAL & INDUSTRIAL MEDICINE CENTER

520 GRIFFIN AVE.

VALDOSTA GA 31601

ALL DRUG SCREENS ARE COLLECTED ACCORDING TO DOT GUIDELINES

EMPLOYER PROFILE

EMPLOYER NAME: _____

PHONE NUMBER: _____ EXT: _____

FAX NUMBER: _____ Is it secure? y n

Call if fax if is not secure P# _____

WORKER'S COMP CONTACT _____ P# _____

DRUG SCREEN CONTACT _____ P# _____

E-Mail CONTACTS _____

AFTER HOURS CONTACT NUMBER _____

PHYSICAL ADDRESS _____

BILLING ADDRESS: _____

SERVICE TYPE: WORKERS COMP / INJURY CARE PROTOCOL

Would you like a Post Accident Drug Screen or Alcohol Screen With Injury Care?

Non DOT 5 7 10 panel DOT Quick screen 5 Quick Screen 10

Breath Alcohol Saliva Alcohol (if positive will follow up with Breath Alcohol)

Name of Physical Therapy

referral: _____

Name of _____

Pharmacy: _____

Name of _____

Orthopedic: _____

Name of ophthalmologist: _____

**We will call the company on all cold urines given or positive quick screens collected
ALL POSITIVE W/C DRUG SCREENS WILL BE SENT FOR CONFIRMATION**

SERVICE TYPE: PHYSICAL EXAMS

Mark type of exam needed: pre-employment Fit for Duty

Non DOT 5 7 10 DOT Return to Duty Re-certification Respirator questionnaire

Spirometry Strength test X-ray / type _____

Audiogram Vision TB skin test Tetanus Hep B series Hair Collection EKG PAE

Labs- please list _____

SERVICE TYPE: DRUG / ALCOHOL TESTING

(no drug or alcohol Screening without picture ID)

Non DOT 5 7 10 DOT Quick screen 5 Quick Screen 10 Saliva Alcohol

Breath Alcohol E-Screen Hair Collection Nicotine Test

Mark what type screening to be done:

Pre-employment Random Reasonable Cause Post Accident Return to Work

Is this to be an Observed Drug Screen? yes no

Would you like to use our lab and MRO? yes no

State name of lab use to use if not using ours: _____

Is this to be a collection only? (if yes that will require your employee to bring the DS form with MRO)

Drug Screen Forms: _____ at our office. _____ Patient Will Bring

Shipping check one: Fedex Courier Lab Corp UPS

Occupational & Industrial Medicine Center

Employer: _____

Phone: _____ Fax: _____

Contact: _____

Mailing Address: _____

Billing Address: _____

Workman's Comp Ins.

Name: _____

Address: _____

Phone: _____ Fax: _____

Contact/ Representative: _____

Stephen Cooper

Phone: 229-249-4010

Fax: 229-249-4009