ExpressMED

Company Service Request Form

Patient Name: _____ Patient Date of Birth: _____

Employer: _____ Job Title: _____

Employer Address:_____

Patient must present Service Request Form and Photo ID at the time of service

Drug Testing
(Check All That Apply):

- ☐ Breath Alcohol
  - ☐ Federal (DOT)
  - ☐ Non-Federal
- ☐ Federal (DOT)
- ☐ Non-Federal
  - ☐ Hair Collection
  - ☐ Saliva Collection
  - ☐ Rapid Drug Screen

Reason for Test

- ☐ Random
- ☐ Pre-Employment
- ☐ Post-Accident
- ☐ Reasonable Suspicion/Cause
- ☐ Return to Duty
- ☐ Follow Up
- ☐ Observed Drug Collection Requested

Special Testing
(Check All That Apply):

- ☐ TB Consult (May Require TSpot and/or Chest X-Ray)
- ☐ Audiogram
- ☐ EKG
- ☐ Work Skills Assessment
- ☐ Respirator Fit Test (OSHA Review Required)
- ☐ OSHA Review
- ☐ PFT (Pulmonary Function Testing)
- ☐ PPD Testing
  - ☐ 1 Step
  - ☐ 2 Step
- ☐ Lift Test - Required Weight:_____lbs.
- ☐ Vision Testing
  - ☐ Jaeger (Near)
  - ☐ Ishihara (Color)
  - ☐ Snellen (Distance)
  - ☐ Depth
  - ☐ Titmus

Examinations
(Check All That Apply):

- ☐ Pre-Employment
- ☐ DOT Physical
  - ☐ New Certification
  - ☐ Recertification
- ☐ 7D Physical
- ☐ Respirator Clearance Exam (OSHA Review, Physical, May Require PFT)
- ☐ Asbestos Physical (OSHA Review, Physical, PFT, Chest X-Ray & B-Read)
- ☐ Silica Physical (OSHA Review, Physical, PFT, Chest X-Ray, B-Read & PPD)
- ☐ Hazmat Physical (OSHA Review, Physical, PFT, & Chest X-Ray)
- ☐ Police Officer Physical
- ☐ Firefighter Physical
- ☐ Fit for Duty (Clearance After A Non-Work Related Injury/Illness)

Injury Treatment

- ☐ Treatment for Work Related Injury
  Date of Injury: _____

Body Part Injured: _____

Additional Comments: _____

☐ CHECK BOX IF EMPLOYEE/PATIENT IS TO PAY FOR SERVICES RENDERED

Blood Work/Titers

☐ MMR ☐ Varicella ☐ Hep B ☐ TSpot ☐ Lead ZZP ☐ Heavy Metals

Vaccinations

☐ Hep A - 2 Shot Series ☐ Hep B - 3 Shot Series ☐ MMR ☐ Varicella ☐ Flu (Seasonal) ☐ TDap

Authorized By: _____ **Date:** _____
(Please Print)

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603.625.2622

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