

REQUEST FOR SERVICES

PLEASE FAX or EMAIL COMPLETED FORM TO: (318) 966-6321(Taudrea.early@stfran.com) OR HAVE THE EMPLOYEE BRING THIS FORM TO OUR CLINIC AT THE ADDRESS ABOVE. ALSO PLEASE BRING IN PHOTO I.D. AT THE TIME OF VISIT OR TEST WILL NOT BE PERFORMED.

EMPLOYEE NAME: _____

EMPLOYEE SSN/ID#: _____

COMPANY NAME: Diocese of Shreveport

METHOD OF PAYMENT: Employee Pays Bill Company Bill Third Party Administrator

BILLING ADDRESS: 3500 Fairfield Avenue, Shreveport, Louisiana 71104

PLEASE MARK THE APPROPRIATE SERVICES THAT ARE REQUESTED:

REASON FOR SCREEN/TESTING: <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Annual <input type="checkbox"/> Random <input type="checkbox"/> New Certification <input type="checkbox"/> Post-Accident <input type="checkbox"/> Recertification <input type="checkbox"/> Return To Work <input type="checkbox"/> Follow Up <input type="checkbox"/> Reasonable <input type="checkbox"/> Other: Suspicion/Cause _____ OBSERVED: <u>Yes / No</u>	DRUG/ALCOHOL SCREEN: <input type="checkbox"/> DOT Drug Screen <input type="checkbox"/> NON-DOT Drug Screen ___5 Panel ___10 Panel _____Other. <input type="checkbox"/> DOT Breath Alcohol <input type="checkbox"/> NON-DOT Breath Alcohol <input checked="" type="checkbox"/> Instant Drug Screen ___5 Panel <input checked="" type="checkbox"/> 10 Panel <input type="checkbox"/> Hair Drug Screen	PHYSICALS: <input type="checkbox"/> DOT <input type="checkbox"/> NON-DOT <input type="checkbox"/> WORK COMP <input type="checkbox"/> ASBESTOS <input type="checkbox"/> CHROMIUM <input type="checkbox"/> HAZWOPER <input type="checkbox"/> HAZ-MAT
OTHER TESTING: <input type="checkbox"/> Blood Work: _____ <input type="checkbox"/> Audio <input type="checkbox"/> EKG <input type="checkbox"/> Vision: ___Titmus ___Snellen Wall Chart <input type="checkbox"/> PFT/Spirometry <input type="checkbox"/> Mask Fit Test ___Portacount Machine ___Hood Test w/Bitter solution <input type="checkbox"/> Respirator Mask Clearance <input type="checkbox"/> TB Skin Test <input type="checkbox"/> Back Assessment/Eval <input type="checkbox"/> Chest X-ray: ___ 1 view ___ 2 view <input type="checkbox"/> Lumbar X-ray <input type="checkbox"/> Other: _____		
REPORTING RESULTS: <input type="checkbox"/> Give all paperwork to employee <input type="checkbox"/> Mail all paperwork to the ___Employer ___Third Party Administrator <input checked="" type="checkbox"/> Fax all paperwork only Fax Number: <u>(318) 868-4609</u> <input type="checkbox"/> Email paperwork only Email: _____		

AUTHORIZED BY: _____ Phone: _____ DATE: _____