UNIVERSAL
OCCUPATIONAL MEDICINE

PATIENT REFERRAL

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

Patient Name: _____

Occupation: _____

Employer: _____

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

Physical: ☐Yes ☐No

Reason: ☐Pre-empt ☐Post-Offer ☐DOT Cert or Recert.
☐FFD/RTW ☐Other:_____

Drug Screen: ☐Yes ☐No

Reason: ☐Pre-emp For Cause ☐Post Injury ☐Random ☐Reasonable Suspicion/ Post Accident
☐Other:_____

Test Type: ☐Rapid Screen_____ ☐Non-DOT ☐DOT

Breath Alcohol Test (BAT): ☐Yes ☐No

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

Test Type: ☐DOT ☐Non-DOT

Additional Testing: ☐Yes ☐No

Test Type: ☐TB ☐Audio ☐Lift Test ☐Spirometry ☐Mask Fit
☐Other:_____ ☐FCE

Reporting Results: ☐Follow Protocol ☐Other:_____

Comments: _____

_____

_____

_____

_____

Authorized by: _____

Phone: _____x_____ **Fax:** _____

Email: _____

UNIVERSAL
OCCUPATIONAL MEDICINE

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Bakersfield, CA 93308
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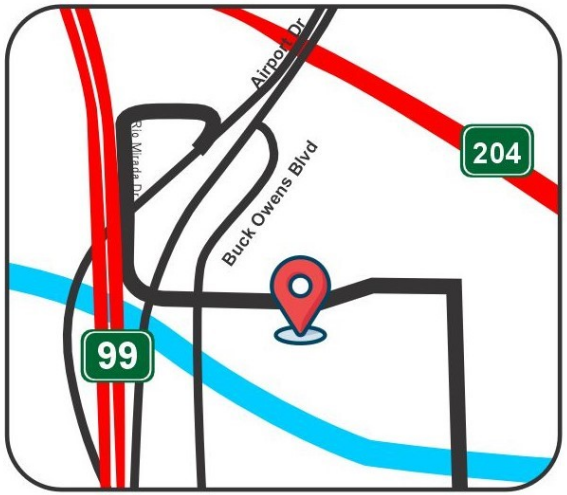

Office Hours:

Monday- Friday
7:00am to 5:30pm

After Hour Services
661.633.2125