Occupational Medicine

Dr. CJ Wolinski MD

Employee/Patient Information

Name _____ Date of Birth _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail Address _____

Employer/Company Information

Company Name _____
Address _____ City _____ State _____ Zip _____
Contact Name _____ Contact Phone _____
Contact E-Mail _____ Contact Fax _____
Preferred Method for Results: ☐ Fax ☐ Email ☐ US Mail

Billing Information

Workers Compensation Carrier

Name _____

Address _____

City _____State ____ Zip _____

Phone _____ Fax _____

Date of Injury _____
Describe incident and body area(s) injured:

Occupational Medicine Invoicing

Name _____

Address _____

City _____State ____ Zip _____

Phone _____ Fax _____

Please check all authorized services below

Exams

- ☐ Dot Exam
- ☐ Pre-Employment Exam
- ☐ Fitness for Work Exam
- ☐ Forklift Exam
- ☐ Return to Work Exam
- ☐ Respirator Exam
- ☐ Return to Work Exam
- ☐ TB Mini Physical
- ☐ Other_____

Drug Screens

- ☐ Company COC/Lab Account
- ☐ CNT COC/Lab Account
- ☐ **Federal**
  - ☐ FMCSA ☐ FRA
  - ☐ PHMSA ☐ FTA
  - ☐ FAA ☐ USCG
- ☐ **Non-Federal Instant Test**
  - ☐ 6 Panel ☐ 10 Panel
- ☐ Reason For Testing
  - ☐ Post-Accident ☐ Pre-employment
  - ☐ Random ☐ Follow-up
  - ☐ Return to Duty ☐ Reasonable Suspicion
- ☐ Observed

Testing

- ☐ Breath Alcohol
- ☐ Strength/Lift Test
- ☐ Audio
- ☐ Back X-ray Views____
- ☐ Chest X-Ray Views____
- ☐ EKG
- ☐ TB Test
- ☐ Vaccine _____
- ☐ Vision _____
- ☐ Other

Authorized by _____ **Title** _____ **Date** _____
Signature _____ **Phone** _____