## **Employee Work-Related - INJURY Visit**

*Today's Date:	*Date of Injury:
*Patient:	*Injury Description:
Birthday:	SSN: xxx-xx
To be completed by Employee Supervisor/DER: (initials:)	
*Company:	*Job Description:
Address:	City, State:
*Supervisor/HR contact:	
*Employer Phone:	Employer Fax:
*Bill to: WorkComp Ins / Company pay	WC Network (if known):
WC Insurance:	Adjuster:
Claim#:	Tele #: fax#:
*Will incident testing be required for this visit? Yes / No (if 'yes' – must select from below)	
Non-DOT Urine Drug Screen - rapid test of	DOT, Urine Drug Screen

Non-DOT Drug Screen – collect & send only

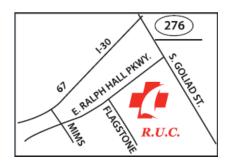
Non-DOT Breath Alcohol

For UDS/Breath Alcohol only, and only assigned by the DER: Reason for Testing:

Pre-Placement / Random / Post-Accident / Reasonable Susp. / Return to Duty / Follow-up

*DER preference for sending Medical Record, Test Results & Return to Work Forms:	
Email:	Fax:
Other Instructions:	

## Urgent Care OPEN 7 DAYS M-F, 8a-8p, S/S 9a-6p / OccMed Mon-Fri: 8a-5p



panel test

**Rockwall – 469-402-3400** 810 E. Ralph Hall Pkwy, 75032

**Royse City – 469-351-0100** 576 W. I-30, 75189

Occupational Medicine/Rockwall 469-402-3420 810 E. Ralph Hall Pkwy, 75032

