



SALES REP: _____
DATE SETUP: _____

PRO MED MINOR EMERGENCY CENTER **OCCUPATIONAL SERVICES PROTOCOL**

COMPANY NAME: _____ # OF EMPLOYEES: _____

PHONE: _____ FAX: _____ *Secure -or- NOT Secure*

PHYSICAL ADDRESS: _____ BILLING ADDRESS: _____

CONTACT PERSON, INJURY CARE: _____ PH: _____ EXT: _____
EMAIL ADDR: _____ CELL#: _____

CONTACT PERSON, PHYSICALS/DRUG SCREENS: _____ PH: _____ EXT: _____
EMAIL ADDR: _____ CELL#: _____

Occupational Services (Non-Injury)

1. Verification:

- A) Will employee bring in Request for Service form? **YES** **NO**
- B) If employee forgets Request for Service form, may we perform services employee verbally requests? **YES** **NO**
If NO, who verifies services needed? _____

2. Drug Screens: Circle all that apply

- A) DOT/NIDA Drug Screen: Pre-employment Random For Cause
- B) NONDOT/NON-NIDA Drug Screen: Pre-employment Random For Cause

3. Lab:

- A) Will your company use the Pro Med lab (Quest)? **YES** **NO**
 - 1. If "YES", how does your company want to receive the results?
FAX **PHONE** **MAIL** **EMAIL:** _____
Who should receive the Drug Screen results? _____
 - 2. If "NO", what lab does your company want to use?
Name of Lab: _____ MRO: _____
Account #: _____ Courier: _____
****Please provide Chain of Custody forms****

4. Breath Alcohol:

- A) DOT BAT: Pre-employment Random For Cause
- B) NON DOT BAT: Pre-employment Random For Cause

Who should receive the BAT results? _____
Designated Employer Representative ("DER") _____ Phone: _____

5. Physical and Special Occupational Services: Circle all that apply

- A) DOT Physicals: Post Offer Recertification
Does patient get DOT Card? Yes or No (Original or Copy)
- B) General Physicals: Pre-Employment Fit for Duty Return to Work
- C) Back Exam/Lift Test: Yes or No

- D) Asbestos Exam: Yes or No
- E) Audiogram: Yes or No
- F) Respirator Questionnaire: Yes or No
- G) Respirator Exam: Yes or No
- H) TB Test Yes or No Chest Xray if Positive? Yes or No or Upon Request, Call _____
- I) Hepatitis B testing Yes or No
- J) Hepatitis A testing Yes or No

How does company want to receive results?: **FAX PHONE MAIL EMAIL**

1) Who should receive the results? _____

WORK COMP INJURIES

1. Verification:

- A) How should front office verify injury?
Contact Co / Form faxed or brought in / Patient will be brought in by: _____
- B) Names of individuals authorized to verify services and/or name of form required: _____

*After hours/Weekends: _____

2. Drug and Alcohol Testing: Circle all that apply

- A) Drug Screen: Mandatory or Upon Request
 Will your company use the Pro Med lab (CRL)? **YES NO**
 1. If "YES", how does your company want to receive the results?
FAX PHONE MAIL EMAIL: _____
Who should receive the Drug Screen results? _____
 2. If "NO", what lab does your company want to use?
 Name of Lab: _____ MRO: _____
 Account #: _____ Courier _____
**Please provide Chain of Custody forms

- B) Breath Alcohol Test: Mandatory or Upon Request
 Who should receive the BAT results? _____
 Designated Employer Representative ("DER") _____ Phone: _____

- C) Do you agree to pay for the first visit the employee sent to Pro Med for a work-related injury has a positive post-accident drug screen? **YES NO**** _____

If no, please note that you will need to contact marketing or client services to discuss an alternative payment agreement)

2. Special Notes:

- A) Approval required for physical therapy &/or Specialist Referrals? **YES NO**
If "YES" who do we call & at what number: _____
- B) Does company have own specialist for referrals? **YES NO**
If "YES" please list specialists: _____
- C) Special company concerns? _____

3. Status Reports:

- A) How would company like to receive work status reporting? **FAX ONLY PHONE/FAX PHONE ONLY**
Who should receive status reports for injured employees? _____

4. Billing for W/C injuries:

- A) Does company have W/C Insurance? **YES NO (Direct Pay)**
 Account#: _____ Carrier/Address: _____
 Case Mgr: _____
 Ph/Fx: _____