IOWA CITY

Exceptional Medicine. Extraordinary Care.

MERCY OCCUPATIONAL HEALTH
www.MercyOccupationalHealth.org

Coral West Medical Center
2769 Heartland Drive, Suite 205
Coralville, IA 52241
(319) 339-3921
Fax (319) 339-3858
Toll Free (800) 637-2942 x 3921

Muscatine Medical Center
2104 Cedarwood Drive, Suite 102
Muscatine, IA 52761
(563) 263-3921
Fax (563) 264-2525
Toll Free (877) 863-3921

Employer Request for Evaluation and Treatment

Appointment Date: ______________________Time: _____

Employee/Patient Name: ____________________________ Date of Birth: _____/_____/_____

Company Name: ____

Company Contact Name: __________________________ Phone: ___________ Fax: _____________

❑ **Initial care for possible work related injury/illness** Dateof Injury ____/____/_____

Description of Injury/Illness ____

____

******I authorize Mercy Occupational Health to evaluate and initiate treatment of the above-named employee. I understand that my company is responsible for payment of the initial visit to help determine continuing responsibility for care. Should this claim be determined "not work-related," I will notify the employee so that alternate medical care can be obtained and notify Mercy Occupational Health that continuing treatment is not authorized by the company.**

Authorized Company Representative ____________________________ Date: _____/_____/_____

Drug and Alcohol Testing

PHOTO ID REQUIRED – In the event that your employee presents to Mercy Occupational Health without a valid government or employer issued photo ID, you will be contacted and asked to send a Supervisor or Human Resource representative, whom also must have a valid photo ID, to verify the identity of your employee.

❑ Urine Drug Screen Collection
❑ DOT (FTA, FAA, FRA, USCG)
5 panel standard test

❑ Breath Alcohol Screening
❑ Non DOT
❑ Standard test (lab results)
❑ Rapid test (instant non-negative results)

❑ Post Accident/Incident
❑ Pre-Employment/Post-Hire
❑ Random
❑ Reasonable Suspicion
❑ Follow-up
❑ Return to Work

❑ 5/6 panel
❑ 9/10 panel

Employer/OSHA Required Evaluations

❑ Pre-Employment/Post-Hire Physical
❑ DOT Medical Exam - ❑ Initial ❑ Re-Certification ❑ Re-Evaluate for Condition
❑ Periodic/Surveillance Exam ❑ Asbestos ❑ Lead Testing ❑ Cadmium ❑ Heavy Metals ❑ Haz-Mat ❑ Other _________
❑ Return to Work Exam
❑ Fit for Duty Exam
❑ Independent Medical Evaluation
❑ Other (please specify) ____

Please specify additional testing below:

❑ Audiogram
❑ Pulmonary Function Test (PFT)
❑ Respirator Fit Testing
❑ Lift Evaluation
❑ EKG

❑ Urine Dip
❑ PPD – TB Test
❑ Snellen Vision
❑ Color Vision
❑ Titmus Vision

❑ Tetanus
❑ Hepatitis B
❑ Hepatitis A
❑ Rubella
❑ Chest X-ray

Blood Draw for Laboratory:
____
____
____
❑ Other ______________

I authorize Mercy Occupational Health to perform testing as indicated above.

Authorized Company Representative ____________________________Date: _____/_____/_____