



Occupational Medicine Services Company Profile

Today's Date: _____

Company Information: Contact Information:

Company Name _____
 Total Number of Employees _____
 Physical Address _____
 City _____
 State _____ Zip _____
 Mailing Address _____
 City _____
 State _____ Zip _____
 Telephone _____
 Fax _____ Is Fax Secure?

Contact #1 _____
 Telephone _____ After Hours Contact
 Cell Phone _____
 Fax _____ Is Fax Secure?
 Email _____
 Contact #2 _____
 Telephone _____ After Hours Contact
 Cell Phone _____
 Fax _____ Is Fax Secure?
 Email _____

Third Party Administrator (TPA):

Company Name _____
 Attention To _____
 Address _____
 City _____ State _____ Zip _____
 Telephone _____ Fax _____ Is Fax Secure?
 Email _____

Bill Workers' Compensation To:

Company Name _____
 Attention To _____
 Address _____
 City _____ State _____ Zip _____
 Telephone _____ Fax _____ Is Fax Secure?
 Send work status to:
 Contact Name: _____ Contact Fax or Email: _____

Bill Physicals and Other Occupational Medicine Services To:

Company Name _____
 Attention To _____
 Address _____
 City _____ State _____ Zip _____
 Telephone _____ Fax _____ Is Fax Secure?
 Send clearance documents to:
 Contact Name: _____ Contact Fax or Email: _____

Bill Drug and Alcohol Testing To:

Same as Physicals Same as Workers' Compensation

Company Name _____

Designated Employer Representative _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____ Is Fax Secure?

Email _____

Preferred Pharmacy (Include BIN #, etc.):

Special Instructions:

Occupational Medicine Services*

Some services not performed at all locations.

<input type="checkbox"/> Audiogram	<input type="checkbox"/> Fit Testing	<input type="checkbox"/> Physical Ability Test
<input type="checkbox"/> Arsenic Screen (urine only)	<input type="checkbox"/> Flu Test - Rapid	<input type="checkbox"/> Provider Review 15min
<input type="checkbox"/> Blood Alcohol	<input type="checkbox"/> Flu Vaccine - High Dose	<input type="checkbox"/> Rabies Vaccine - Rabavert
<input type="checkbox"/> Breath Alcohol	<input type="checkbox"/> Flu Vaccine - Regular	<input type="checkbox"/> Spirometry
<input type="checkbox"/> Breath Alcohol Confirmation	<input type="checkbox"/> Heavy Metal Screen	<input type="checkbox"/> Stool Cards x 3
<input type="checkbox"/> CBC with Diff	<input type="checkbox"/> Hep A Titer	<input type="checkbox"/> Tdap Immunization
<input type="checkbox"/> Chest X-ray 1V	<input type="checkbox"/> Hep B Core Antibody	<input type="checkbox"/> Tdap Titer
<input type="checkbox"/> Chest X-ray 2V	<input type="checkbox"/> Hep B Surface Antibody Titer	<input type="checkbox"/> Thyroid Panel (TSH,T3,T4)
<input type="checkbox"/> Cholinesterase	<input type="checkbox"/> Hep B Surface Antigen	<input type="checkbox"/> Thyroid (TSH)
<input type="checkbox"/> Chromium Screen	<input type="checkbox"/> Hep B Vaccine (1 dose)	<input type="checkbox"/> Titmus Vision
<input type="checkbox"/> CMP	<input type="checkbox"/> Hep C Antibody Titer	<input type="checkbox"/> Treadmill Stress Test
<input type="checkbox"/> Coronary Artery Calcium	<input type="checkbox"/> HIV 1&2	<input type="checkbox"/> Tuberculosis Blood Test
<input type="checkbox"/> COVID-19 Test - PCR	<input type="checkbox"/> HIV Screen - Rapid	<input type="checkbox"/> Tuberculosis Skin Test
<input type="checkbox"/> COVID-19 Test - Rapid	<input type="checkbox"/> Lipid Panel	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> COVID-19 Vaccine	<input type="checkbox"/> Lipoprotein A	<input type="checkbox"/> Varicella
<input type="checkbox"/> DOT Physical	<input type="checkbox"/> Microalbumin	<input type="checkbox"/> Varicella Titer
<input type="checkbox"/> EKG	<input type="checkbox"/> MMR Titer	<input type="checkbox"/> Vision Exam (Color/Near/Depth)
<input type="checkbox"/> Executive Blood Profile	<input type="checkbox"/> MMR Vaccine (1 dose)	<input type="checkbox"/> Workers' Comp Telemedicine Visit
<input type="checkbox"/> Fingerstick Glucose	<input type="checkbox"/> Non-DOT Physical	<input type="checkbox"/> ZPP w/ Lead

*This is for Company Profile set-up only. Examinations will only be performed when indicated on the employee's Authorization for Treatment form.

Drug Screen Services

Drug Screen Oral Fluid Send Out

- 6 Panel (THC, COC, OPI, AMP, mAMP, PCP)
- 7 Panel (THC, COC, OPI, OXY, AMP, mAMP, PCP)
- 9 Panel (THC, COC, OPI, AMP, mAMP, PCP, BENZ, MTD, OXY)
- 9 Panel, no THC (COC, OPI, AMP, mAMP, PCP, BENZ, MTD, OXY, BUP)
- 10 Panel (THC, COC, OPI, AMP, mAMP, PCP, BENZ, MTD, OXY, BUP)

Drug Screen Rapid (Oral/Urine)

- Oral Fluid 5 Panel (AMP, COC, mAMP, OPI, THC)
- Oral Fluid 6 Panel (AMP, COC, mAMP, OPI, OXY, THC)
- Oral Fluid 6 Panel, Benzo cutoff level (AMP, COC, mAMP, OPI, BZO, THC)
- Oral Fluid 8 Panel w/saliva indicator (AMP, BUP, BZO, COC, mAMP, OPI, OXY, THC)
- Urine 6 Panel (THC, COC, AMP, OPI, OXY, PCP, 6 MAM)
- Urine 10 Panel (THC, COC, AMP, OPI, OXY, PCP, BARB, BENZ, MTD, PPX)
- Urine 11 Panel, minus THC (OPI, AMP, ECT, BARB, BZO, MTD, THC, PCP, BUP)
- Urine 14 Panel (AMP, mAMP, MDMA/MDA, BARB, THC, COC, OPI [Codeine, Morphine, 6-MAM, HYC, HYM, Oxy, Oxymorphone])

Drug Screen Urine Send Out (DOT/Non-DOT)

- DOT 5 Panel Urine (THC, COC, AMP, OPI, [OXY], [6 MAM], PCP)
- NonDOT 4 Panel Urine w/o THC (COC, OPI, [OXY], AMP, PCP)
- NonDOT 5 Panel (AMP, COC, mAMP, OPI, THC)
- NonDOT 9 Panel (THC, COC, AMP, MDMA, OPI, [OXY], PCP, BARB, BENZ, MTD)
- NonDOT 9 Panel Urine w/o THC (COC, AMP, OPI, OXY, PCP, BARB, BENZ, MTD, PPX)
- NonDOT 9 Panel Urine + Mep/Tram (THC, COC, AMP, OPI, OXY, PCP, BARB, BENZ, MTD, PPX, MEP, TRAM)
- NonDOT 10 Panel Urine (THC, COC, AMP, OPI, OXY, PCP, BARB, BENZ, MTD, PPX)
- NonDOT 11 Panel Urine (OPI, AMP, ECT, BARB, BZO, MTD, THC, PCP, BUP)
- NonDOT 12 Panel Urine [9 panel+ Fent/Mep/Tram] (THC, COC, AMP, OPI, OXY, PCP, BARB, BENZ, MTD, PPX, FENT, MEP, TRAM)

Additional Drug Screen Services

- Drug Screen Collection Only (DOT/Non-DOT)
- Drug Screen Self-Pay (All Non-DOT types)
- Drug Screen Hair Collection - 5 Panel (THC, COC, AMP, OPI, OXY, PCP)

Atrium Health Contact Information

Atrium Health Contact: _____

Telephone: _____

Email: _____