OCCUPATIONAL HEALTH & WELLNESS CENTER

DEARBORN COUNTY HOSPITAL

600 Wilson Creek Road, Lawrenceburg, IN 47025 - **GROUND LEVEL**
730am-5:00pm
812-537-8323 Phone
Please FAX this form to: 812-537-8343 or
employee may present to Occupational Health & Wellness Center

AUTHORIZATION FOR SERVICES

Company Name:_____ Secure Fax_____

Employee Name:_____Address:_____

Employee Phone:_____(Cell)_____(Home) DOB: _____

PHYSICALS

___Pre-employment
___DOT Physical
___Return to Work/Follow up after Injury
___Hazmat
___Respiratory Clearance
___Fire/Police

VACCINATIONS

___Hepatitis B
___Flu
___Tetanus (Tdap, Td)
___TB Skin Test
__Hepatitis
__MMR
__Varicella

DRUG & ALCOHOL TESTING

Please select one from each of the 4 sections below:

1.___Pre-placement ___Random ___Post-Accident ___Reasonable Suspicion

2.___DOT or ___NON-DOT (DOT=Department of Transportation/Drivers)

3.___COLLECTION ONLY ___ DCH-5 PANEL ___DCH-10 PANEL ___DAY CARE DRUG SCREEN

4. **Breath Alcohol Test ___YES or ___NO**

TESTING

___Audiogram or___Whisper Test
___Functional Capacity Exam
___Chest X Ray___One View___Two View
___Vision Exam_____Titmus or____Snellen
___PFT
___EKG
___Respiratory Fit Test
___Physical Therapy

LAB TESTING

___CBC
___ Lipid Profile
___ Lead (blood) Chemistry
___ Urinalysis
___MMR Titer
___Varicella Titer
___Hepatitis B Titer
___A1C

INJURY

Minor Injuries are treated in Occupational Health- Ground Floor
To ensure accurate billing and timely service, please complete the following:

Nature of Injury_____

Date/Time of Injury_____

Bill to_____

Billing Address_____

Billing Phone_____

***Please call 8323 with claim number or write here*_____

Company authorization for treatment and billing/payment:

Company Signature _____

Date_____Phone_____

Company is billed for all services unless noted above. Payment is due within 60 days of service.

This form can be found on the Occupational Health & Wellness page of the dch.org website.