Occupational Medicine

SAVE FORM

PRINT FORM

Screening/Medical Treatment Authorization

This form should be faxed, emailed or brought to the Clinic.
Employee must have a photo ID at time of service.

Employer

Company Name & Address: _____

Phone: _____ Fax: _____ Contact Email: _____

Bill this entity for Services: ☐ Company ☐ Work Comp Insurance ☐ Other (list) _____

Authorizing Person:_____Signature:_____

Employee

Full Name: _____ SSN: _____ DOB: _____ Injury Date: _____
(if applicable)

Drug Screening

☐ Collection Only (send to your MRO/Lab)

Agency: ☐ Non-Federal (Non-DOT)

☐ Federal (DOT) *Provide the testing authority/Agency*: _____

Reason: ☐ Pre-placement ☐ Random ☐ Post-Accident ☐ Reasonable Cause

☐ Return-to-Duty ☐ Follow-up

Sample Type: ☐ Urine ☐ *Collect Observed* ☐ Blood ☐ Saliva ☐ Hair

Drug Screen Panels:

Urine Panels: ☐ 10 Panel ☐ 9 Panel (minus THC) ☐ 12 Panel* ☐ 5 Panel ☐ RAPID

☐ DOT Panel ☐ 9 Panel ☐ 12 Panel minus THC*

Hair Panels: ☐ 5 Panel ☐ 5 Panel+Opiates *Includes Suboxone & Oxycodone

Breath Alcohol Testing

Breath Alcohol Testing (BAT): ☐ Non-DOT ☐ DOT

Collection Site Location

Smyth Co Community Hospital
245 Medical Park Drive
Marion, VA 24354
Phone 276-378-1117
Fax 276-378-1130
smythcountyoccupationalmedicineclinic@balladhealth.org