AFFINITY HEALTH GROUP

SERVICES REQUEST FORM

AFFINITY INDUSTRIAL MEDICINE
920 Oliver Road Suite I • Monroe, LA 71201
Phone: (318) 812-7563 • Fax: (318) 812-7563
Email: AIMC@ahphysician.com

Employer Name: ______________________________
Employer Address: ______________________________
Employer Phone: ______________ Employer Fax: ______________
Contact Name: ______________ Email: ______________

Employee: ______________
Employee DOB: ______________
Employee SSN: ______________

DRUG/ALCOHOL/HAIR TESTING

- Breath Alcohol Test DOT ☐
- Breath Alcohol Test NON-DOT ☐
- Drug Screen DOT ☐
- Drug Screen Hair ☐
- Drug Screen NON-DOT (sendoff) ☐
- Drug Screen Quick ☐ 5 Panel ☐ 10 Panel

REASONS FOR DRUG/ALCOHOL TESTING

- Follow Up ☐
- Post-Accident ☐
- Post-Incident ☐
- Pre-Access ☐
- Pre-Employment ☐
- Promotional ☐
- Random ☐
- Reasonable Suspicion ☐
- Recertification ☐
- Return to Duty/Fitness for Duty ☐

PHYSICAL EXAMINATIONS

- DOT Medical Exam ☐
- Non-DOT Agility Test/Back Eval ☐
- Non-DOT Basic Medical Exam ☐
- Asbestos ☐
- Chromium ☐
- Crane Operator ☐
- Hazmat ☐

REASONS FOR PHYSICAL EXAM TESTING

- Annual ☐
- Follow Up ☐
- New Certification ☐
- Pre-Employment ☐
- Recertification ☐
- Return to Duty/Fitness for Duty ☐

WORK COMP INJURY TREATMENT

- Treatment of Industrial Injuries ☐
- Injury Date:
- Body Part Injured:

VACCINES

- Hepatitis A ☐
- Hepatitis B ☐ #1 ☐ #2 ☐ #3
- Influenza ☐
- Measles, Mumps & Rubella (MMR) ☐
- Meningococcal ☐
- Tetanus ☐
- Tetanus, Diphtheria & Pertussis (TDAP) ☐
- Tuberculosis Skin Test (TBST) ☐
- TwinRix ☐ #1 ☐ #2 ☐ #3
- Varicella ☐

TITERS

- Hepatitis B ☐
- Measles, Mumps & Rubella (MMR) ☐
- Varicella ☐

LAB TESTING

- Blood Lead ☐
- Complete Blood Count (CBC) ☐
- Comprehensive Metabolic Panel (CMP) ☐
- Heavy Metals ☐
- HIV ☐
- QuantiFERON Gold Plus ☐
- SMA 24 ☐
- VDRL/RPR ☐
- Zinc Protoporphyrin (ZPP) ☐

OTHER MEDICAL COMPONENTS

- Audiogram ☐ Initial ☐ Annual
- Back/Lumber X-Ray ☐
- Chest X-Ray 1 View ☐
- Chest X-Ray 2 View ☐
- Pulmonary Function Test/Spirometry ☐
- Respiratory Clearance ☐
- Respirator Mask Fit Questionnaire ☐
- Respirator Mask Fit Test ☐
  - # of Mask Fits: ☐ #1 ☐ #2 ☐ #3
  - Style: ☐ Half-Face ☐ Full-Face ☐ Both
  - Type: ☐ Qualitative ☐ Quantitative ☐ Both
- N95 Fit Test ☐
- Snellen Vision ☐
- Titmus Vision ☐
- Urinalysis Complete ☐
- Urinalysis Dip Test ☐

BILLING INSTRUCTIONS

Bill ALL services to:

- ☐ Employer
- ☐ Employee
- ☐ TPA: ______________
- ☐ WC Carrier: ______________
- Claim #: ______________

IF YOUR COMPANY REQUIRES SPLIT BILLING, PLEASE INDICATE BELOW:

For drug and/or breath alcohol test, bill to:

- ☐ Employer
- ☐ Employee
- ☐ TPA: ______________
- ☐ WC Carrier: ______________
- Claim #: ______________

For physical, bill to:

- ☐ Employer
- ☐ Employee
- ☐ TPA: ______________
- ☐ WC Carrier: ______________
- Claim #: ______________

For work comp treatment, bill to:

- ☐ Employer
- ☐ Employee
- ☐ TPA: ______________
- ☐ WC Carrier: ______________
- Claim #: ______________

*SEND RESULTS VIA:

☐ Mail ☐ Email ☐ Fax

____
AUTHORIZING SIGNATURE

____
DATE

*In order to ensure that our clinic performs the correct services you need for your candidate/employee, utilization of this form is mandatory. This completed form is required before your candidate/employee is seen in our clinic. It can be faxed to (318) 812-7563 or emailed to AIMC@ahgphysician.com.