Affinity Industrial Medicine Clinic (AIMC)
920 Oliver Road Suite I ▪ Monroe, LA 71201
P: (318) 812-7559 ▪ F: (318) 812-7563
Email: AIMC@ahgphysician.com

AIMC Service Request Form

Employer Name: ____

Employer Address: ____

Employer Phone: __________________ Employer Fax: _________________

Contact Name: ____

Email: ____

Employee: ________________________________

Employee DOB: ____________________________

Employee SSN: ____________________________

Appointment: _____________________________

ALCOHOL/DRUG/HAIR TESTING	
Breath Alcohol Test DOT	
Breath Alcohol Test NON-DOT	
Drug Screen DOT (sendoff)	
Drug Screen NON-DOT (sendoff)	
Drug Screen Quick ☐5 Panel ☐10 Panel	
Drug Screen Hair	
****OBSERVED?***	
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	
U.S. Coast Guard	
Reasons for Physical Exam Testing	
Annual	
Follow Up	
Initial	
New Certification	
Pre-Employment	
Recertification	
Return to Duty/Fitness for Duty	
WORK INJURY/INCIDENT	
Treatment of Work Injury/Incident	

Injury/Incident Date: ________________

Body Part: ______________________

WC Visit: ☐#1 ☐#2 ☐#3 ☐#4 ☐#5
☐#6 ☐#7 ☐#8 ☐#9 ☐#10

VACCINES	
Hepatitis A	
Hepatitis B ☐#1 ☐#2 ☐#3	
Influenza	
Measles, Mumps & Rubella (MMR)	
Meningococcal	
Tetanus	
Tetanus, Diphtheria & Pertussis (TDAP)	
Tuberculosis Skin Test (TBST)	
TBST Reading Results	
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	
Hemoccult	
HIV	
QuantiFERON Gold Plus	
VDRL/RPR	
Zinc Protoporphyrin (ZPP)	
OTHER MEDICAL COMPONETS	
Audiogram ☐Initial ☐Annual	
Back/Lumber X-Ray	
Chest X-Ray 1 View	
Chest X-Ray 2 View	
Electrocardiogram (ECG or EKG)	
Pulmonary Function Test/Spirometry	
Respirator 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/Ishihara Vision (Color)	
Urinalysis Complete (Send to lab)	
Urinalysis Dip Test (Done in clinic)	

BILLING INSTRUCTIONS

Bill **ALL** services to:
☐ Employer
☐ Employee
☐ Self-Pay
☐ 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.