SELF REGIONAL HEALTHCARE
OCCUPATIONAL HEALTH SERVICES

Company Profile

Company Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Billing Address: _____ City: _____ State: ____ Zip Code: _____

For Workers Comp Issues: Job Restrictions, Return to Duty, Referrals & Authorizations, etc:

Primary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

Secondary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

For Administrative, Billing, and Account Issues:

Primary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

Secondary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

For Issues Regarding Drug and Alcohol Testing and Reporting (no one other than these individuals can receive this information):

Primary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

Secondary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

After Hours / Emergency Contact Name: _____ Phone: _____

PLEASE INDICATE HOW PAPERWORK SHOULD BE SENT TO YOUR COMPANY:

Send paperwork to the attention of: _____

❑ Fax Secure Fax Number: _____

❑ E-mail Address: _____

❑ Mail Address: _____

Improving the health of your workforce

occmed@selfmedicalgroup.org

OHS - Greenwood
105 Vine Crest Ct, Suite 300
Greenwood, SC 29646
Phone: (864) 223-6625
Fax: (864) 388-2171

OHS - North Saluda
595 Newberry Highway
Saluda, SC 29138
Phone: (864) 445-2500
Fax: (864) 445-3956

OHS - Edgefield
200 Ridge Medical Plaza
Edgefield, SC 29824
Phone: (803) 637-3146
Fax: (803) 637-6597

OHS - Laurens
22580 Hwy. 76-East
Laurens, SC 29360
Phone: (864) 939-1078
Fax: (864) 725-3808

OHS - South Saluda
102 R.L. Sawyer MD Drive
Saluda, SC 29138
Phone: (864) 445-2173
Fax: (864) 445-9158

OHS - Newberry
2605 Kinard St, Suite 200
Newberry, SC 29108
Phone: (803) 597-4036
Fax: (864) 725-3080

Number of employees:

Total (Approx): _____ If applicable: Administrative: _____ Production: _____ DOT: _____

PLEASE SELECT WHICH SERVICES YOUR COMPANY WILL / MAY UTILIZE AND COMPLETE THE CORRESPONDING FORMATION:

❑ **Employment Examinations / Services**

Please indicate which examinations you expect to utilize. This is for company profile set-up only. Examinations will only be performed when indicated on the employee's Authorization for Treatment form.

- ❑ Non-DOT physical with urinalysis dipstick (glucose test)
- ❑ DOT Physical with urinalysis dipstick (glucose test)
- ❑ Audiometric testing
- ❑ Respiratory review
- ❑ Pulmonary function test
- ❑ TB skin test
- ❑ Hepatitis B vaccine
- ❑ Respirator fit test
- ❑ Vision testing
- ❑ Tetanus / Td / Tdap (circle one)
- ❑ Blood test to document immunity following Hepatitis B vaccination series (Recommended).

❑ **Drug Screening**

If Selecting this service, please complete the separate drug/alcohol screening form and Security Certification Statement.

❑ **Breath Alcohol Testing**

If selecting this service, please complete the separate drug/alcohol screening form and Security Certification Statement.

❑ **Workers Compensation**

1. Would you like employees with a Workers Compensation claim undergo a drug test on their initial visit? ❑ Yes ❑ No
   This testing must be performed within 32 hours of the incident.
2. Would you like employees with a Workers Comp. claim undergo a breath alcohol test on their initial visit? ❑ Yes ❑ No
   This testing must be performed within 8 hours of the incident.

If yes to either, please complete the separate drug/alcohol screening form and Security Certification Statement.

3. Who should be billed for Workers Compensation services: ❑ Company ❑ Third Party Administrator ❑ Carrier ❑ Other: _____

Workers Compensation Insurance Carrier: _____ Policy No: _____

Contact Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Third Party Administrator (TPA): _____ Policy No: _____

Contact Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

The following questions are to solicit your preferences when additional services are recommended. We have preferred providers that we recommend for some of these services, but can accommodate your preferences.

Laboratory for Drug Screens: ❑ Quest Diagnostics ❑ Other: _____

Laboratory for blood and other services: ❑ Self Regional ❑ Other: _____

Diagnostic Imaging: ❑ Self Regional ❑ Other: _____

Pharmacy (when prescriptions are needed): _____

Durable Medical Equipment (splints, etc): _____

Physical therapy / Rehabilitation: ❑ Optimum Life Center ❑ Other: _____

Orthopedic Consultation: ❑ Orthopedic Assoc. of the Lakelands ❑ Other: _____

Spine / Pain Management: ❑ Advanced Spine & Neurosurgical Assoc ❑ Other: _____

_____ _____ _____

Print Name *Signature* **Date**

Occupational Health Services also offers additional services including Executive Health Services, Biometric Health Screening, Wellness Services, and others. Pleas contact our office if you would like to consider utilizing these or other services.

SELF REGIONAL HEALTHCARE
OCCUPATIONAL HEALTH SERVICES

DRUG & ALCOHOL TESTING SELECTION FORM

Company Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Billing Address: _____ City: _____ Zip Code: _____

Drug and alcohol testing can be used in many different circumstances. Please review the list below and select which drug and/or alcohol screening panel(s) your company will utilize. For each selection, be sure to indicate which type of drug test to be performed. We will be happy to assist you in making a selection based on your individual needs

For Issues Regarding Drug and Alcohol Testing and Reporting (no one other than these individuals can receive this information):

Primary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

Secondary Contact: _____ Title: _____

Work Phone: _____ Cell Phone: _____

Secure Fax Number: _____ E-mail Address: _____

After Hours / Emergency Contact Name: _____ Phone: _____

❑ **Pre-Employment Drug Screening**
- ❑ Urine 10 Panel ❑ Urine 9 Panel ❑ DOT Panel
- ❑ Urine Rapid 10 Panel ❑ Saliva 6 Panel ❑ Hair Extended Panel
- ❑ Urine Healthcare Professional Panel ❑ Rohypnol ❑ GHB ❑ Ecstacy ❑ Other: _____

❑ **Workers Compensation/Post-Accident Drug Screening (to be performed within 32 hours of incident)**
- ❑ Urine 10 Panel ❑ Urine 9 Panel ❑ DOT Panel
- ❑ Urine Rapid 10 Panel ❑ Saliva 6 Panel ❑ Hair Extended Panel
- ❑ Urine Healthcare Professional Panel ❑ Rohypnol ❑ GHB ❑ Ecstacy ❑ Other: _____

❑ **Random Drug Screening**
- ❑ Urine 10 Panel ❑ Urine 9 Panel ❑ DOT Panel
- ❑ Urine Rapid 10 Panel ❑ Saliva 6 Panel ❑ Hair Extended Panel
- ❑ Urine Healthcare Professional Panel ❑ Rohypnol ❑ GHB ❑ Ecstacy ❑ Other: _____

❑ **For Cause Drug Screening**
- ❑ Urine 10 Panel ❑ Urine 9 Panel ❑ DOT Panel
- ❑ Urine Rapid 10 Panel ❑ Saliva 6 Panel ❑ Hair Extended Panel
- ❑ Urine Healthcare Professional Panel ❑ Rohypnol ❑ GHB ❑ Ecstacy ❑ Other: _____

❑ **Return to Duty Screening**
- ❑ Urine 10 Panel ❑ Urine 9 Panel ❑ DOT Panel
- ❑ Urine Rapid 10 Panel ❑ Saliva 6 Panel ❑ Hair Extended Panel
- ❑ Urine Healthcare Professional Panel ❑ Rohypnol ❑ GHB ❑ Ecstacy ❑ Other: _____

❑ **Workers Compensation/Post Accident Breath Alcohol Testing (to be performed within 8 hours of incident)**
- ❑ DOT ❑ Non-DOT ❑ With breath confirmation ❑ With blood confirmation

❑ **Random Breath Alcohol Testing**
- ❑ DOT ❑ Non-DOT ❑ With breath confirmation ❑ With blood confirmation

_____ _____ _____

Print Name *Signature* **Date**

DRUG PANELS

Urine 10 Panel

Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Marijuana
Methadone
Methaqualone
Opiates PCP
Propoxyphene

Rapid Urine 10 Panel

Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Marijuana
Methadone
Meth-amphetamines
Opiates PCP
Propoxyphene

Urine 9 Panel

Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Marijuana
Methadone
Opiates
PCP
Propoxyphene

DOT Panel

Amphetamines
Cocaine
Hydrocodone
Hydromorphone
Marijuana
Opiates
Oxycodone
Oxymorphone
PCP

Urine Healthcare Professional Panel

Amphetamines
Barbiturates
Benzodiazepines
Cocaine
Fentanyl
Marijuana
Meperidine
Methadone
Meth-amphetamines
Opiates
Oxycodone
PCP
Propoxyphene
Tramadol

Saliva 6 Panel

Amphetamines
Cocaine
Marijuana
Meth-amphetamines
Opiates
PCP

Hair

Amphetamines
Cocaine
Marijuana
Opiates
PCP

Selected Brand Names and Street Names

Amphetamines (Adderall, Dexedrine)
Benzodiazepines (Xanax, Librium, Valium, Tranxene, Ativan, Serax, Klonopin, Versed, Restoril, Halcion)
Fentanyl (Duragesic, Actiq, Sublimaze, Apache, China Girl)
Hydrocodone (Lorcet, Lortab, Norco, Vicodin)
Hydromorphone (Dilaudid)
Meth-amphetamines (Desoxyn)
Methylphenidate (Ritalin, Concerta)
Oxycodone (Percocet, Tylox, Roxicodone, OxyContin)
Oxymorphone (Opana)
Phencyclidine (Sernyl, PCP, Angel Dust, Tic Tac, Zoom)
Propoxyphene (Darvon, Darvocet)
Tramadol (Ultram)

Club Drug Tests (each separate)

Flunitrazepam (Rohypnol)
Gamma Hydroxybutyrate (GHB)
Methylenedioxy-methamphetamine or MDMA (Ecstacy)