Valley Medical Center

*Remarkable things happen here.*

# *Referral Form* (Please complete form.)

***Patients MUST provide photo ID for all services.***

Date _____

Employee Name _____

Job Position _____

Company _____

Address _____

Is this employee hired through a temporary agency? ❑ Yes ❑ No

If "Yes," name the temporary agency _____

Company Contact Name (for regular & after hours) _____

Telephone _____

Remarks _____

## *PLEASE MARK ALL APPROPRIATE BOXES*

### PHYSICALS

❑ DOT Exam: ___ Pre-placement
___ Periodic

❑ Pre-placement exam

❑ Periodic exam

❑ Audiogram exam

❑ Spriometric exam

❑ Return-to-work exam

❑ Fit-for-duty exam

❑ Other exam

### DRUG SCREENS

❑ NIDA (DOT) ❑ NON-NIDA (Non-DOT)

❑ RAPID ❑ ESCREEN ❑ BREATH ALCOHOL

❑ Post-accident

❑ Random

❑ Return-to-work

❑ For-cause

❑ Follow-up

### OTHER

❑ Treatment of injury/illness ❑ Immunizations

❑ Travel medicine (call in advance) specify country _____

❑ Other _____ (specify)

*See other side for directions to Occupational Health Services.*