URINE DRUG SCREEN & PHYSICAL EXAM REQUISITION

Must be completed by Employer/Requestor

SERVICES REQUESTED (Please select all that apply.)

☐ Urine Drug Screen ☐ CDL Physical ☐ Pre-Employment Physical

If Urine Drug Screen is to be performed, please identify the reason for the screen.

☐ Accident ☐ Pre-Employment ☐ Random ☐ Return to Work ☐ Suspicion

If a physical exam is to be performed, please indicate the provider and appointment date and time.

Provider: ______________________________ Date: ________________ Time: ____________

EMPLOYEE INFORMATION

Name: ____ DOB: ____________________

Social Security Number: ______________________________

BILLING INFORMATION (Please identify who is responsible for payment.)

☐ Employer ☐ Third Party Administrator / Consortium ☐ Employee

Name: ____

Contact Name: ____
(If different from above)

Mailing Address: ____

City/State: ____________________________________ Zip Code: ____________________

Phone Number: ___________________________ Fax Number: ________________________

I authorize payment to the provider for services rendered.

Guarantor Signature: ____ Date: ____________

Revised 06/2021

EMPLOYEE CONSENT

I hereby consent to a physical exam and/or urine drug screen. I further consent to allow the results to be divulged to my employer or its authorized agent, designee, or representative. I agree to hold harmless Electra Hospital District and all providers, employees and agents who work or perform services for Electra Hospital District from any action that may arise out of such results being divulged to my employer.

Employee/Guardian Signature: ______________________________ Date: ____________

Guardian Name: ______________________________

Please bring completed requisition on day of services or fax to the appropriate location.

Electra Memorial Hospital	Fax: (940) 495 - 4137
Electra Medical Clinic	Fax: (940) 495 - 3171
Iowa Park Clinic	Fax: (940) 592 - 4820

ELECTRA HOSPITAL DISTRICT PERSONNEL

Clinic Account Number: ______________________________

Hospital Account Number: ______________________________

Registration Personnel Name: ______________________________ Date: ____________

Please indicate laboratory service provided.

Third Party / Consortium Chain of Custody (Panhandler, Pipeline Testing, etc.)

☐ DOT Urine Collection (SO) ☐ Non-DOT Urine Collection (SO)

ALERE Electra Memorial Hospital Chain of Custody

☐ DOT Urine Drug Screen (SO) ☐ Non-DOT Urine Drug Screen (SO)

MEDTOX Chain of Custody (if applicable)

☐ Industrial Drug Screen (IH)

Laboratory Personnel Name: ______________________________ Date: ____________

NOTE: Send outs (SO) are sent to an outside laboratory for testing. In-house (IH) tests are performed at EMH laboratory.