FAX OR SEND WITH EMPLOYEE

MedStat
Lutheran Health Network

MedStat Warsaw: Phone: (574) 372-7637
Fax: (574) 372-7614
MedStat Syracuse: Phone: (574) 457-8682
Fax: (574) 372-8687

OCCUPATIONAL HEALTH/WORK COMP PRE-REGISTRATION

To be Completed by the Employer

EMPLOYER INFORMATION:

Company Contact: _____ Today's Date: _____

Company: _____ Date of Appt.:_____

Address: _____ Phone: _____

City: _____ St: _____ Zip: _____ Fax: _____

This employee of our company requires the following services:

- ☐ Injury Care
- ☐ Injury Care with Drug or Alcohol Screen
- ☐ Re-check / Re-evaluation
- ☐ Breath Alcohol Screen
- ☐ 10-Panel Drug Screen
- ☐ 10-Panel Urine Drug and Alcohol Screen
- ☐ NIDA Drug Screen (DOT)
- ☐ 5-Panel Drug Screen
- ☐ 5-Panel Rapid Drug Screen
- ☐ Pre-Employment Physical
- ☐ CDL/DOT Physical
- ☐ Respirator Physical
- ☐ Mantoux (TB Test)
- ☐ Hepatitis B Vaccine
- ☐ Hepatitis B Titer

Special Instructions: _____

_____

Authorized by: _____

Location authorized: ☐ MedStat Warsaw
1500 Provident Dr. Ste. A

☐ MedStat Syracuse
107 W. Pickwick Dr. Ste. A

A Photo I.D. is REQUIRED for all Drug and Alcohol Testing

To be Completed by the Employee

EMPLOYEE INFORMATION:

Last Name: _____ First & Middle Name: _____

Address: _____ Home Phone: _____

City: _____ St: _____ Zip: _____ Cell Phone: _____

Sex: ____ (M/F) Marital Status: ___ (S/M) Date of Birth: _____ SS#: _____

To be Completed at MedStat

Consent to Treatment

I hereby consent to and authorize my physician, other designated physician, and associated medical staff the administration and performance of all treatment, minor operations, and procedures, which, in the judgment of the physicians or designated alternate, may be considered necessary or advisable for my care. If I do not comply with the medical program of care provided or recommended by my physician or designated alternate, I understand that such action may result in adverse medical consequences and I then relieve my physician, designated alternate, and associated medical staff of all responsibility for consequences resulting from my action.

If my treatment is necessary due to an on the job injury (a workers' compensation claim), then I hereby authorize the physician to release any medical or financial information to all such entities that are responsible for adjudicating the claim, including, but not limited to, the Indiana Workers' Compensation Board, my employer, and any third party payer/administrator, medical claims review agent, or their legal representatives.

1. Have you read this form or had this form read to you? ☐ Yes ☐ No
2. Do you understand this form? ☐ Yes ☐ No
3. Do you have any questions? ☐ Yes ☐ No Patient Initials: _____
4. Have you received a copy of our privacy notice? ☐ Yes ☐ No Patient Initials: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____