Prairie Ridge HEALTH

Inspired by you

**PATIENT NAME:** _____

**MRN:** _____

**PRH OFFICE USE ONLY ACCT #:** _____

**2023**

## OCCUPATIONAL HEALTH SERVICE AUTHORIZATION

**Form must be filled out in full for all Occupational Health visits. Completed forms may be: sent with employee or provided prior via fax (920-623-1237) or online at www.PrairieRidge.Health/OccHealth**

*Need to talk to someone after-hours?? 920-623-6424 (ER registration desk)*

1) **Reason:** ☐ Pre-employment ☐ Random ☐ Reasonable Suspicion ☐ Post-accident ☐ Return to duty ☐ Follow-up ☐ Other

2) **DOT:** ☐ Non-DOT or ☐DOT DOT Agency: ☐FMCSA ☐USCG ☐ HHS ☐FTA ☐FRA ☐NRC ☐PHMSA ☐FAA

3) **Employee Information** _____
Name/Position of Hire Date of Birth

_____
Address City/State/Zip Phone

4) **Persons/Organizations Authorized to Disclose Patient's Health Information:**
Name & Address of Service Provider:
Prairie Ridge Health
1515 Park Avenue
Columbus, WI 53925

5) **Person(s)/Organization(s) Authorized to Receive Patient's Health Information*:**

6) **Person(s)/Organization(s) Responsible for Billing*:**

7) **Health Information to be disclosed:** *(Check applicable information.)*

**LAB ALCOHOL AND DRUG TESTING**
☐ **Perform testing established in contract**
OR
☐ Drug Screen Collection
☐ Rapid Drug Screen 5
☐ Rapid Drug Screen 10
☐ Breath Alcohol Test

Optional:
☐ Call result to DER ASAP
☐ Observed Collection

**ADDITIONAL LAB SERVICES**
☐ Hepatitis B Titer
☐ Lead Blood (OSHA)
☐ ZPP (With Lead Blood-OSHA)
☐ DOT Urine Dip for DOT Physical
☐ Complete Metabolic Panel
☐ QuantiFeron Gold

**VACCINATIONS**
☐ Hepatitis B Vaccine
☐ Flu Vaccine
☐ TB Skin Tests
☐ DTaP (Diptheria, Tetanus and Pertussis)
☐ DT (Diptheria and Tetanus)
☐ Tetanus Only

**RESPIRATORY THERAPY**
☐ Industrial Pulmonary Function Test and Reading
☐ Respiratory Mask Fit (per person)
☐ EKG with Reading
☐ Chest X-ray

**AUDIOLOGY**
☐ Audiogram (Industrial Hearing Screen)/Person
☐ Ear Molds (Set of 2)

**OCCUPATIONAL HEALTH**
☐ Pre-Placement Job Specific Evaluation (Mini Physical)
☐ Nurse Evaluation Only
☐ OCC Health Hourly Nurse Fee
☐ OCC Health Travel Charge >45 miles RT
☐ School District Employee Physical
☐ Human Performance Evaluation

**DOT PHYSICAL:**
☐ Fed Med Card ☐ MV3030B S or P Endorsement
☐ DOT Physical Follow Up
☐ Medical Follow Up
☐ MD Medical Evaluation/Physical
☐ MD Hourly Fee

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8) **Purpose of Disclosure:** Employment Requirements

9) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:**

i. **Right to Inspect or Copy:** I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this Authorization.

ii. **Right to Receive Copy of Authorization:** I understand that if I agree to sign this Authorization, which I am not required to do, I will be provided with a signed copy of this Authorization.

iii. **Right to Refuse to Sign Authorization:** I understand that this Authorization is voluntary and that I may refuse to sign this Authorization. Unless allowed by law, my refusal to sign this Authorization will not affect my ability to obtain treatment from Prairie Ridge Health ("PRH"). *However, I also understand that the occupational health services that I receive from PRH are provided for the purpose of disclosing the results to my employer or other third party. Refusal to sign this Authorization may result in a refusal by PRH to provide me with the specific occupational health services (non-treatment related) that have been requested.*

iv. **Right to Revoke Authorization:** I understand that written notification must be presented to PRH to cancel this Authorization. I understand that my withdrawal will not be effective as to uses and/or disclosures of health information already made in reliance on this Authorization.

10) **Expiration Date:** This Authorization is good until the following date(s)/event: _____
If no date or event is specified, this Authorization will expire one (1) year from the date signed.

**Note: The occupational health services that you receive from Prairie Ridge Health, Inc. ("PRH") are provided for the Purpose of disclosing the results to your employer or other third party. Refusal to sign this Authorization may result in a refusal by PRH to provide you with the specific occupational health services (non-treatment related) that have been requested.**

*** REDISCLOSURE NOTICE:** I understand that if the person(s)/organization(s) listed on this form are not governed by Federal privacy laws, the health information disclosed as a result of this Authorization may be re-disclosed by the recipient and no longer be protected by such laws.

I have had an opportunity to review and understand the content of this Authorization. By signing this Authorization, I am confirming that it accurately reflects my wishes.

11) **Signature of Patient/Legal Rep:**_____**If Federal, Do NOT sign) Date:**_____
Relationship or Authority to Act for the Patient _____
*(If you are signing as a parent of the minor patient listed above, you are declaring that you have not been denied physical placement of the child.)*

12) **Employee Witness (required only when patient is not physically able to sign his/her entire signature):**

Signature _____ Title _____ Date _____

**ONCE SIGNED: Please fax this form to 920-623-1237 or send with patient before services can be rendered.**