



Occupational Health Service Request

Employee Name _____

Company Name _____

Service Request _____

Today's Date _____

Authorized by _____

Phone _____ Fax _____

Signature _____

Who is to receive confidential employee information related to health services requested?

Name _____ Title _____

Phone _____ Secured Fax* _____

*If no secure fax line what secure method of confidential communication does your company request?

Exam Services (Employee must have valid proof of personal identification)

___ **Pre-Employment Physical Exam** (Please provide required company forms and job description)

___ **DOT Physical Exam** or ___ **DOT Recertification Physical Exam**

___ **Audiometric Testing (OSHA Certified Hearing Booth)**

___ **Pulmonary Function Test (PFT)**

___ **Lab Testing** (Please provide specific lab test requirements e.g. Blood Lead Level or Arsenic Testing)

___ **EKG**

___ **Other** _____

Drug Testing (Please indicate what type of testing is required per your company's written policy)

___ **Federally Mandated Testing** (DOT covered employees) or ___ **Non-Federally Mandated Testing*** (Non DOT)

___ Pre-Employment

___ Pre-Employment

___ Post-Accident

___ Post-Accident

___ Reasonable Suspicion

___ Reasonable Suspicion

___ Random

___ Random

___ Return to Duty

___ Return to Duty

*Urine _____ or *Hair Test _____

___ **Specimen Collection Only** (Employer to supply Chain of Custody forms & designated lab information)

Breath Alcohol Testing (Please indicate what type of testing is required per your company's written policy)

___ **Federally Mandated Testing** (DOT covered employees) or ___ **Non-Federally Mandated Testing** (Non DOT)

___ Pre-Employment

___ Pre-Employment

___ Post-Accident

___ Post-Accident

___ Reasonable Suspicion

___ Reasonable Suspicion

___ Random

___ Random

___ Return to Duty

___ Return to Duty

Broadmoor Medical Clinic (South)

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Monday - Friday 8:00 am - 5:00 pm