



Injury Referral Form

Employee Name _____

Company Name _____

Type of Injury _____

Today's Date _____

Date of Injury _____ Shift _____

Comments _____

Authorized by _____

Phone _____ Fax _____

Signature _____

Please indicate below your company's requested services

Evaluation and treatment for a work related injury

Post –Accident Drug Testing

Please indicate what type of urine drug screen required per your company's written policy.

_____ **Federally Mandated Testing** (As required per DOT covered employees)

_____ **Non-Federally Mandated Testing** (Instant Screen & Lab Based Testing for Non-DOT employees)

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

Post- Accident Breath Alcohol Testing (BAT)

If Breath Alcohol Test required please indicate what type required per your company's written policy.

_____ **Federally Mandated Testing** (DOT)

_____ **Non-Federally Mandated Testing** (Non-DOT)

Broadmoor Medical Clinic
1299 Lake Plaza Drive, Colorado Springs, CO 80906
PH: 719-527-1728 FAX: 719-527-1749

Monday –Friday 8:00 am – 5:00 pm