PROMPTMED OCCUPATIONAL HEALTH
2502 E. 25TH STREET COLUMBUS, IN 47201
PH:(812)372-8883 FAX:(812)372-8964

PATIENT INFORMATION (Please Print)					
Today's date:		**Date of Injury:**			
Patient's Last Name:		**First:**		**Middle Initial:**	
Social Security #:	**E-Mail address:**	**Age:**	**Birth date:**	**Sex:**	
			/ /	❑ M	❑ F
Street address:		**City:**		**State/Zip**	
Home Phone #:	**Cell Phone#:**	**Emergency Contact/Relationship:**	**Emergency Contact Phone #:**		
( )	( )		( )		
Employer (Requesting Testing):	**Employer Address:**		**Employer phone #:**		
			( )		
Department:	**Contact Person At Work (supervisor or person who sent you):**		**Phone # of Contact:**		
			( )		
If this is an Injury/Illness please describe (be specific including L for left side and R for right side):		**Date injury was reported to employer:**			
		/ /			

CONSENT FOR TESTING, RELEASE OF RESULTS, FINANCIAL POLICY

In the event that my employer requires substance testing, I consent to allow Prompt Med to collect urine, blood, saliva, breath, or hair sample(s) for testing any or all of the following: drug, controlled substances or alcohol. Under certain circumstances, direct observation may be required to ensure integrity of the specimen. Observed collections will be handled by a member of Prompt Med Staff or a physician.

Further, I give consent for the release of test results to the appropriate members of the Company's management. I understand that the consequences of any positive results are determined by the Company, and not Prompt Med, or the testing laboratory.

In the event the Company does not pay for the services I received, I understand I will be responsible for the balance.

_____ _____
Signature of Patient/Employee Date

REASON FOR TEST (CIRCLE)

☐PRE-EMPLOYMENT ☐RANDOM DRUG SCREEN ☐JOB CHANGE ☐COURT ORDER ☐WORK COMP
☐ REASONABLE CAUSE ☐POST ACCIDENT ☐VOLUNTARY ☐OTHER_____

10/6/14