



CORPORATE PROTOCOL / EMPLOYER INFORMATION

In order for a Company to use our Occupational Medicine Services this form must be completed, signed and submitted to our practice for initial account set-up. This information is required only once and will not need to be submitted with each Employee sent for services.

Date: _____
Company Name: _____ Contact: _____
Company Address: _____ Telephone #: _____
Fax #: _____ Email: _____
Authorizing Personnel: _____ Telephone #: _____
After Hours Contact: _____ After Hours Telephone #: _____
Worker's Compensation Insurance Carrier: _____
Address: _____
Telephone #: _____ Fax #: _____
Claim #: _____ Adjuster: _____

Does your company require a:

Company Medical Transcript: [] Yes [] No Work Status Note: [] Yes [] No
How would you prefer to receive this information?
[] Fax #: _____ OR [] Email: _____ Attention to: _____

Drug Screen on all new cases? [] Yes [] No
Ten-Panel Rapid [] Yes [] No OR Ten-Panel w/ MRO review [] Yes [] No
If the ten-panel rapid returns a NON-NEGATIVE result, do you require a ten-panel with MRO review?
[] Yes [] No

Will company pay for Drug Screen? [] Yes [] No
Will injured worker be accompanied by a Supervisor? [] Yes [] No
Will injured worker have Hard Copy Authorization to evaluate and treat? [] Yes [] No
If not, who do we contact for Hard Copy Authorization? _____
Is Authorization required for Follow-up Visits? [] Yes [] No

Does the company have modified/light duty in place? [] Yes [] No
(Employee can be assigned modified/light duty instead of days off, if applicable)
Is Authorization required for Referrals to Specialist or Special Testing? [] Yes [] No
Will the company be making appointments for Referrals? [] Yes [] No
Does the company have a designated Pharmacy? [] Yes [] No
(If so, please let us know which Pharmacy: _____)

Our facility is here to provide a service for the Injured Worker and for the Employer, so please let us know if there are any special instructions we may assist you with.

Authorized Signature _____ Date _____

20 NW 67th Street, Suite E
Lawton, OK 73505
580 536 9400
580 536 9401 Fax

www.wellfasturgentcare.com

1902 E. Gore Blvd.
Lawton, OK 73501
580 357 4200
580 357 4201 Fax