

Hours: Monday - Friday 8 a.m. - 5 p.m.

CedarValleyMedical.com

Patient Name:		Date of Birth:			
Company:					
Work Address:		City:	State:	Zip:	
Phone:		Fax:			
Authorized by:			Date:		
Work-Related Injury/Illness	Specific Body Part: - If this incident is deemed not work-related, the authorizing organization will be responsible for charges prior to written notification.				
DOT	☐ Drug Screen ☐ Pre-Placement ☐ Follow-up	☐ Alcohol Screen ☐ Post-Accident ☐ Witness/Observed	☐ Reasonable Suspicion☐ Employee to Pay	□ Random	
Non-DOT	☐ Drug Screen ☐ Pre-Placement ☐ Follow-up ☐ 5-panel	☐ Alcohol Screen ☐ Post-Accident ☐ Employee to Pay ☐ 5-panel NO THC	□ Reasonable Suspicion □ 7-panel	□ Random	
Physical Exam (check all that apply)	□ DOT □ Employee to pay	☐ Return to Work ☐ Other:	□ Pre-Placement	☐ Respiratory Cle	arance
Immunization (check all that apply)	☐ Hep B☐ Employee to pay	□ Flu □ Other:	□ТВ	□ Tdap	
Other Services (check all that apply)	□ PFT □ Other:	□ Audiometry	☐ Fit Test		