

Western Reserve Hospital Occupational Medicine 1900 23rd Street, Suite 404 Cuyahoga Falls, OH 44223

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	AUTHORIZATION AND REFERRAL FO	DRM
DATE:		
EMPLOYEE NAME:		
JOB TITLE:		
COMPANY:		
PLEASE CHECK ALL REQUIRED SERVICES BELOW:		
	PHOTO ID REQUIRED	
INJURY TREATMENT:		
□Date of Injury (DOI):		
□Managed Care Organizatio	n (MCO):	
BACKGROUND CHECK: (PLEASE INCL	UDE REQUIRED BACKGROUND CHEC	CK CODE)
□FEDERAL/BCI		
□BCI Only		
PHYSICAL EXAM	SUBSTANCE TESTING	IMMUNIZATIONS
□PREEMPLOYMENT	□URINE DRUG SCREEN	□MANTOUX
□RETURN TO WORK	□DOT □NON-DOT	□ONE STEP
□DOT	□PREEMPLOYMENT	□TWO STEP
□PREEMPLOYMENT	□POST ACCIDENT	□HEPATITIS B VACCINE
□RECERTIFICATION	□RANDOM	□HEPATITIS B TITER
□T8	□FOR CAUSE	□MMR
		□VARICELLA
□PREEMPLOYMENT	□BREATH ALCOHOL	□TDAP
□ANNUAL	□DOT □NON-DOT	□FLU SHOT
	□PREEMPLOYMENT	
	□POST ACCIDENT	
	□RANDOM	
	□FOR CAUSE	
	□HAIR DRUG SCREEN	
	□PREEMPLOYMENT	
	□POST ACCIDENT	
	□FOR CAUSE	
	SERVICES AUTHORIZED BY:	
COMPANY REPRESENTATIVE:		
TITLE:		
PHONE NUMBER:		
EMAIL ADDRESS:		
COMMENTS/SPECIAL INSTRUCTIONS	S:	

Closed All Major Holidays



Restroom