CADUCEUS

REQUIRED TO COMPLETE

PATIENT INFORMATION

Patient's Name
Date of Birth
Driver's License Number
Company Name
Branch

BILLING INFORMATION

- ☐ Employer Paid
- ☐ Carrier Paid
- ☐ TPA Paid
- ☐ Self-Pay

REQUIRED - AUTHORIZER

Authorizer's Name
Email Address
Phone Number

FOR WORKERS' COMPENSATION INJURY

Date of Injury
Insurance Carrier Name
Claim Number for Patient
Last 4 Digits of SSN

- ☐ Injury Type
- ☐ Follow-Up
- ☐ Physical Therapy

CORPORATE SERVICES

Physical Examination

- ☐ Agility Testing
- ☐ Annual
- ☐ Basic or Non-DOT
- ☐ DOT
- ☐ Fitness for Duty
- ☐ Haz-Mat
- ☐ Respirator Clearance
- ☐ Return to Work

Substance Abuse Testing

☐ Breath Alcohol Test	☐ DOT	☐ Non-DOT
☐ Drug Screen Collection - specimen goes to lab	☐ DOT	☐ Non-DOT
☐ Hair Collection	☐ 5 Panel	☐ 10 Panel
☐ Rapid Express Test	☐ Collection Only	☐ Company Supplied

Reason for Substance Abuse Testing

- ☐ Pre-Emlpoyment
- ☐ Post Accident
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Return to Duty
- ☐ Follow-Up
- ☐ Other _____

Special Requirements

- ☐ Audiogram
- ☐ EKG
- ☐ Pulmonary Function Test - Spirometry
- ☐ Silica Respirator Exam
- ☐ TB Skin Test
- ☐ Titers _____
- ☐ Vaccination _____
- ☐ Vision Screening
- ☐ X-Ray _____

Special Notes for Caduceus

Other service to provide or comments to our team.

ALL SECTIONS MUST BE COMPLETED FOR SERVICES TO BE RENDERED.