Adventist Health Castle

❒ **PEARL CITY**
1245 Kuala Street, St 103
Pearl City, HI 96782
P: 808.784.2273
F: 808.456.2274

❒ **KAPOLEI**
890 Kamokila Blvd., Suite 106
Kapolei, HI 96707
P: 808.521.2273
F: 808.521.2274

❒ **KAILUA**
660 Kailua Road
Kailua, HI 96734
P: 808.263.2273
F: 808.263.2274

❒ **WAIKIKI**
1860 Ala Moana Blvd., #101
Honolulu, HI 96815
P: 808.921.2273
F: 808.921.2274

EMPLOYER REQUEST FOR EXAMINATION/TREATMENT

Please have your employee(s) provide this form at the time of visit. You are also welcome to fax this prior to your employee(s) visit. Form must include a designated employee representative and phone number. No appointment is necessary.

Date of Request:_____ ***Requests are kept for a period of one month from the 'Date of Request indicated.***

Employee Name:_____ **Date of Birth:**_____

Company Name:_____

Company Phone:_____ Company Fax:_____

Company Address:_____
Street Address *City/State/Zip Code*

Designated Employee Rep (DER):_____ DER Phone:_____

REASON FOR REQUEST OF EXAM/TREATMENT

❒ Pre-employment ❑ Post-Accident ❑ Return-to-Duty ❑ Random ❑ Reasonable Cause

❒ Workers Compensation/Work Related Injury ❑ Other:_____

****Please complete section 'For Work Related Injury Only below*

FOR WORK RELATED INJURY *ONLY*

Work Restrictions Availability: ❑ Modified ❑ Light ❑ No Duty Available

❒ **Additional Procedure(s):** ❑ Yes ❑ No (*If yes, please check all that apply in the 'Requested Service(s) below)*

WC INSURANCE:_____ **CLAIM NUMBER** *if applicable*:_____

ADJUSTER NAME:_____

PHONE NUMBER:_____ **FAX NUMBER:**_____

****We will notify you if your employees' injury requires **First Aid Treatment vs. Workers Compensation** (OSHA Recordable). First Aid Treatment is billed directly to the company using our Fee for Service rates and not to the insurance carrier****

HOW WOULD YOU LIKE TO RECEIVE RESULTS &/OR MEDICAL TRANSCRIPTIONS

❒ I have an account, please use my account preference

❒ I'd like to use a different route this time: ❑ Fax ❑ Mail ❑ Email Address:_____

****For emails, the temporary password **UC1245** has been used.*

REQUESTED SERVICE(S): *Select all that apply*

DRUG &/OR ALCOHOL SCREENING:

***Specify DOT Agency (please select one):**

❍FMCSA ❍FAA ❍FRA ❍FTA ❍PHMSA ❍USCG

❒ Non DOT Panel 5 ❑ DOT Panel 5 ❑ Non-DOT Panel 10

❒ DOT/Non DOT Urine Drug Screen Collection Only

❒ Instant Panel 5

❒ Instant Panel 12

❑ Instant Panel with reflex to Non DOT Panel 5

❒ DOT Alcohol Testing **Pearl City Only*

RESPIRATOR:

❒ Respirator Clearance – (**will proceed to Respirator Physical Exam if failed for Respirator Questionnaire)*

❒ Respirator Physical Exam

❒ Qualitative Respirator FIT Test – (**have employee bring Respiratory masks*)

❒ Pulmonary Function Test (PFT)

IMMUNIZATIONS:

❒ Tetanus ❑ Flu ❑TB/PPD

❒ Hepatitis B Series – (Series of 3 shots)

❒ Hepatitis A Series – (Series of 2 shots)

PHYSICAL EXAMINATION (Vision and Whisper Test included):

❒ Pre-Employment ❑ Return to Work/Fit for Duty/Basic

❒ DOT/CDL Physical ❑ Tiers of Care (DOT/CDL Exclusivity Rates)

LABORATORY TESTS:

❒ Laboratory *Collection Only (DLS will bill you with additional costs)*

❒ Hep B ❒Hep A ❒CBC ❒ Zinc Protoporhin ❒ Lead ❒Heavy Metal

❒ Covid-19 RNA by PCR (Nasal Swab) ❒Covid-19 Anti-bodies (Blood Test)

❑ Covid-19 Rapid Antigen Test (Nasal Swab)

❑ Rapid Covid-19 PCR Test

EMPLOYER AUTHORIZATION

Authorized by:_____ _____

Signature *Print Name*

By signing I am authorizing services and hereby making a guarantee of payment for services requested on this form.

Revise date: *11/30/2021*