St Luke's™ Magic Valley

775 Pole Line Road, Suite 101  Ph: 208-814-8100

# SERVICES REQUEST FORM

**Company Name:** _____

**Employee Name:** _____ **( PICTURE ID REQUIRED)**

## WORK INJURY MANAGEMENT:

Drug Screen required: Yes ☐ No ☐

Employer Contact Person/ Phone: _____

Work Comp. Carrier: _____

First Report of Injury completed: Yes ☐ No ☐

## DRUG FREE WORKPLACE SCREENING:

☐ DOT Drug Screen ☐ Non-DOT Drug Screen

☐ Breath Alcohol Test

Please check reason for test:

☐ Baseline ☐ Reasonable Suspicion

☐ Pre-Employment ☐ Return To Duty

☐ Random ☐ Follow-Up

☐ Post Accident ☐ Other_____

**Please report to your designated collection site as soon as possible after being notified.**

(If you utilize St. Luke's Occupational Health Services, hours are: M – F, 8AM – 6PM; After-hours, report to St. Luke's Clinic-Physicians Center, M-F, 6PM – 8PM; outside these hours, if you cannot wait until regular hours, please report to the Emergency Department.)

## PHYSICALS/SCREENS:

☐ DOT ☐ Pre-employment (Post offer) ☐ Vision

☐ Functional Ability (by P.T.) ☐ Respirator ☐ Hearing

☐ Spirometry ☐ Other _____

**Authorized by:** _____ **Date:** _____