Treatment Form

convenientMD

EMPLOYER & EMPLOYEE INFORMATION

EMPLOYER: Manchester Community College

EMPLOYEE / APPLICANT:

AUTHORIZED BY: Erica Bernier RN/ Nikola Barchey **EXPIRATION DATE:** 12/2026

SERVICES REQUIRED:

EXAMINATIONS & TESTING - SELF PAY

Amount is due at the time fo service

- Pre-Employment Physical ☐
- Pre-Employment DOT Physical ☐
- Re-Certification DOT Physical ☐
- 2-Step TB Skin Test ☐
  Return within 1-3 weeks from 1st TB Read to finish the process
- X-Ray (1 view) (TB Screening) ☐
  Documentation of a positive result is required
- TB - QuantiFERON Blood Draw (Lab Test Code: 182879) ☒
- MMR Titer (Lab Test Code: 058495) ☐
- Varicella Ab, IgG Titer (Lab Test Code: 096206) ☐
- Hep B Surface Ab Qualitative Titer (Lab Test Code: 006395) ☐

CLINICAL TEAM: Please select An Employer Paid Service under the Location in the Lab Interface when ordering the test. STOP

DRUG TESTING TYPE - SELF PAY

Amount is due at the time of service

- 12 Panel Rapid (With Non-DOT Chain of Custody) ☒

DRUG TESTING REASON FOR TEST

- Pre-employment ☒

VACCINATIONS & INJECTIONS - SELF PAY

Amount is due at the time of service

- Tdap ☐
- Hep B (series of 3) ☐
- Varicella ☐
- MMR ☐

INSTRUCTIONS FOR CONVENIENTMD TEAM FOR SELF-PAY SERVICES:

- ☑ Amount is due at the time of service - follow company protocol to determine the price
- ☑ Select 'Employer Paid Service' as Visit Type
- ☑ Enter 'Manchester Community College' as the Employer

RESULTS

ConvenientMD Staff: Please verify account protocol on the Occupational Health Directory

Date of Service: **Patient ID:**

Clinic Location:

	Pending/ CCF Sent out	Pass/ Negative	
12 Panel Rapid Drug Screen When results are negative attach DocuTAP Printout*	☐	☐	_____ (Initials)

STOP **If requested and not completed, select reason below:** ☐ Outside of hours ☐ Unable to provide sample ☐ Other _____

	Pending	Pass	Fail	
Pre-Employment Physical	☐	☐	☐	_____ (Initials)
Pre-Employment DOT Physical	☐	☐	☐	_____ (Initials)
Re-Certification DOT Physical Attach DOT Physical Card*	☐	☐	☐	_____ (Initials)

	Pending	1st Read	Pending	2nd Read	
2-Step TB Skin Test Please send Read/ Plant to employer per Occ Health Directory*	☐	☐	☐	☐	_____ (Initials)

	Pending	
TB - QuantiFERON Blood Draw Confirm **'An Employer Paid Service'** was selected in Lab Interface*	☐	_____ (Initials)

	Normal	Abnormal	
X-Ray (1 view) (TB Screening) Attach Teleradiology Report*	☐	☐	_____ (Initials)

	Pending	Immunity Verified*	
MMR Titer	☐	☐	_____ (Initials)
Varicella Titer	☐	☐	_____ (Initials)
Hep B Titer Attach Immunization Records if Applicable*	☐	☐	_____ (Initials)

	Administered	
Tdap (Vaccine) Attach Immunization Consent Form*	☐	_____ (Initials)

	1st Dose	2nd Dose	3rd Dose	
Varicella (Vaccine Series of 2)	☐	☐		_____ (Initials)
MMR (Vaccine Series of 2)	☐	☐		_____ (Initials)
Hep B (Vaccine series of 3) Attach Immunization Consent Form*	☐	☐	☐	_____ (Initials)

Comments

Revised 5/13/2024

self pay