

Treatment Form



EMPLOYER & EMPLOYEE INFORMATION

EMPLOYER:

EMPLOYEE / APPLICANT:

AUTHORIZED BY:
EXPIRATION DATE:

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.**



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 _____ (Initials)
 12 Panel Rapid Drug Screen
 When results are negative attach DocuTAP Printout*

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

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

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

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

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

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

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

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

Comments

Revised 5/13/2024