



PATIENT REFERRAL

Date: _____

Expires: _____ @ _____ a.m./p.m.

Employee: _____

Occupation: _____

Employer: _____

Requested Treatment:

Treat Injury/Illness

Date of Injury: _____

Drug Screening:

Yes

No

Quick Screen

Non-DOT

Hair

DOT - Pre-Emp

DOT Random

DOT Post Acc

Breath Alcohol Testing:

Non-DOT

DOT

Physical:

Pre-Emp

DOT Initial

Environmental

DOT Recert

Annual Phy

Functional

Capacity Exam

FFD/RTW

Audiogram

TB Skin Test

Spirometry

Test Results Reporting:

Call Results

Fax Results

Mail Results

E-mail Results

Comments: _____

Authorized by: _____

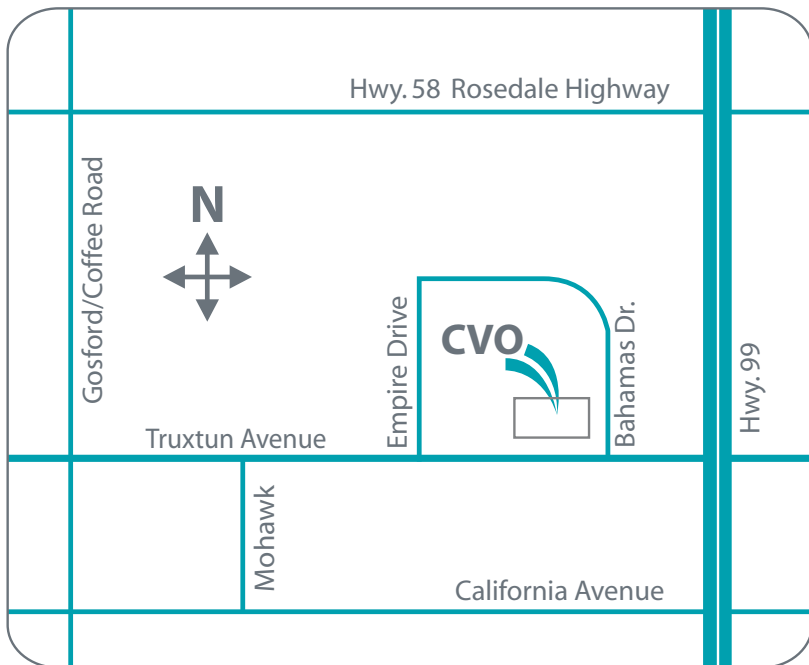
Telephone: _____ x _____ Fax: _____





Central Valley Occupational
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Bakersfield, CA 93309
661.632.1540



**24-Hour Work Comp Coverage
After Hours, Weekends, and Holidays**

Office Hours:
Monday-Friday
7:30 a.m. - 5:30 p.m.