



BUSINESS HEALTH PARTNERS

COMPANY: _____ DATE: _____

EMPLOYEE NAME: _____ PO#: _____

SS#: _____ POSITION: _____

REQUESTED BY: _____ CONTACT#: _____

REASON FOR TEST:

(After marking your reason for test you will then need to select required testing below.)

- PRE-ACCESS/ENTRY
- FOLLOW-UP
- RETURN TO WORK
- PRE-EMPLOYMENT
- RANDOM
- POST-ACCIDENT
- REASONABLE CAUSE
- PERIODIC / ANNUAL
- OTHER _____

LAB TESTS

- SMAC / CBC (LIVER)
- CBC
- URINALYSIS
- BLOOD LEAD / ZPP
- URINE PHENOL
- BLOOD BENZENE
- COVID AG NASAL SWAB
- COVID PCR NASAL SWAB
- OTHER _____

FIT TEST

- OSHA RESPIRATOR QUESTIONNAIRE (PFT Review)
- PULMONARY FUNCTION
- 1/2 FACE _____
- FULL FACE _____

DRUG SCREENS

- NON DOT
- DOT
- HAIR TEST __5__10
- QUICK TEST __5__9__10
- ORAL FLUID
- DISA

AUDIOMETRY

- BASELINE
- COMPARISON

ALCOHOL TESTING

- NON DOT
- DOT
- BREATH
- DISA
- SALIVA

PHYSICAL EXAM

- DOT/CDL
- COAST GUARD EXAM
- BASIC EXAM
- RETURN TO WORK
- CRANE OPERATOR
- FIT FOR DUTY
- FCE

OTHER SERVICES

- EKG
- CHEST X-RAY
- LUMBAR X-RAY
- VISION (TITMUS)
- IMMUNIZATION _____
- 1 VIEW
- 2 VIEW
- 2 VIEW
- 3 VIEW
- ISHIHARA
- 5 VIEW
- OTHER _____

MCALLEN

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