VELOCITY URGENT CARE
IN PARTNERSHIP WITH SENTARA

NEW CLIENT ACCOUNT

Welcome to Velocity Urgent Care!

Thank you for choosing Velocity Urgent Care for your Occupational Health needs. Velocity Urgent Care offers a variety of services for employers to include:

- Company physicals from simple pre-employment to many federally regulated physicals.
- We offer Drug and Alcohol screening services, laboratory testing to include titers, and vaccines.
- Ancillary Services including PFT/Spirometry, Audiometry, Vision testing and Respirator FIT Testing.
- Our X-ray services offered for Employer Health include regular chest x-rays
- Our capabilities expand to offering *B-read (Chest X-ray w/B-read required for Asbestos and Crystalline Silica Surveillance physicals every 3 years per OSHA regulations.)

In addition to the above Employer Health Services we can extend to our clients' services for Work Related Injuries.

Complete the following and return:

TYPE OF INDUSTRY: _____

What kind of services/products does your company provide? _____

Are there hazardous substances _____

Name of Company_____

Physical location (Street address) _____

City/State/Zip code_____

Phone Number_____ Fax_____

Contact Person_____Title_____
Phone _____ Email Address _____

Company Billing Address if different from the above:

Street Address_____

City/State/Zip_____

Do you have a company **DER** *(Designated Employee Representative)* for company drug and alcohol testing? If yes please provide their name and contact information

Name_____ Phone/Fax Number_____

Email Address_____

Contact Person(s) to Authorized Medical Treatment for employees for both Employee Health Services and for Workman's Comp?

EHS (Name/Title/Phone) _____

WC (Name/Title/Phone) _____

****PROVIDE AN AFTER-HOURS EMERGENCY CONTACT **DIFFERENT** FROM THE ABOVE****

Name and Phone Number_____

Treatment Authorization Forms will be attached to this email, please make sure when sending an employee in for services that the **Employee Health Services** form is completed and comes with the employee or fax the **completed** document ahead to the clinic of choice.

The same applies to the **Workmen's Comp** Authorization for Treatment Form. These documents must be completed for services to be rendered, this is an effort to prevent unauthorized services being provided to your employees and for us to ensure we are providing the services you are requesting. If the employee arrives for services without the supporting documents a phone call will be placed to those listed as contacts for verbal authorization prior to providing the service. If no verbal authorization can be obtained services may be delayed.

Treatment for work related emergent injuries will not be delayed, employee will be treated, and you, the company will be notified after the fact, so please have an **after hours** emergency contact person listed.

WORKMAN'S COMPENSATION INFORMATION

complete only if we are providing care for work related injury or illness.

Workers Compensation Carrier: _____

Address:_____

City/State/ZIP_____Phone:_____

Fax:_____ Contact Person:_____

Policy Number: _____ Email Address: _____

Does your Company require a Drug and/or Breath Alcohol Test for post-accident injuries? YES or NO

Type of Test requested (see choices on the Drug Screen Page)_____

What type of work does employee do and what is the employees normal schedule hours or workweek? _____Can you accommodate restrictive or light duty if needed? YES or NO

Who should receive information regarding WC visit, treatment plan and test results? _____
How should they be sent? Fax, Email or regular mail? _____

Select from the following **EMPLOYER HEALTH SERVICES** – check all that apply

Physical Exams:

_____DOT/CDL

_____Pre-Employment Medical Physical
Does your company have a specific physical form that we should use? __**Yes** __**No** If yes please provide at time of visit

_____Respirator Clearance Exam

_____Respirator FIT Test (Qualitative)

_____OSHA Surveillance Exam (see below regarding Haz-Mat exposure)

(What substances might your employees be exposed to? Check all that apply)

_____ Asbestos _____Crystalline Silica _____Lead _____ Hexavalent Chromium

_____ Other: _____

Laboratory Services:

____ CMP (complete metabolic panel) ____CBC (complete blood count) ____ Lipid Panel

____ Hepatitis "A" Titer ____ Hepatitis "B" Titer ____ Hepatitis "C" Titer

____ MMR Titer _____ Varicella Titer ____ HIV ____ Lead

____QuantiFERON TB (***Interferon-gamma release assay (IGRA) for Mycobacterium tuberculosis***) Other (specify) _____

COVID PCR SWAB(LAB BASED) _____ COVID RAPID(IN-HOUSE-SAME DAY RESULT) _____
COVID ANTIBODY-BLOOD-SERUM (lab based) _____

Vaccines:

_____ Flu _____Hepatitis "A" Series _____ Hepatitis "B" Series _____Tetanus/Diphtheria (Td)

_____ Tetanus/Diphtheria/Pertussis (Tdap) _____MMR _____ Varicella _____ Typhoid (must be ordered)

_____ PPD TB Skin Test (must be able to return to clinic & be read by medical 48 to 72 hours after it has been placed)

_____ Other: _____

Ancillary Services:

_____ PFT/Spirometry _____Respirator FIT Testing _____ Chest X-ray

_____ Vision – (Titmus available at select clinics) _____ Audiometry (Booths available at select clinics)

_____ Chest X-ray w/ B read (required for Asbestos & Crystalline Silica Surveillance physicals ever 3 years per OSHA regulations)

Medical Forms: _____OSHA Medical Questionnaire _____TB Risk Assessment Questionnaire

DRUG AND ALCOHOL TESTING (please read carefully before making your selection(s), if you have questions please call our Occupational Health Services Dept for guidance or refer to your Company Policy Requirements)

Drug Screens: *(a variety of drug screening services are offered please select what best suits the needs of your company and your company's workplace policy)*

Rapid (Instant) Urine Drug Screen _____ 5 Panel _____11 Panel *Note that any **non-negative** results will be sent to Labcorp for lab confirmation before resulting to employer. Choose the reason for the test below

_____Pre-Employment _____Post Accident _____Reasonable Suspicion ____ Random

RESULTS – PLEASE SPECIIFY WHO NEEDS TO RECEIVE DRUG SCREEN RESULTS AND HOW THEY WANT TO RECEIVE THEM (example: Fax, Email, mail) _____

Drug Screens: (Federal Mandated Drug & Alcohol Screening and Company Policy)

Will your company provide Velocity UC with your compan**y's** Chain of Custody Forms in advance? YES or NO
Will your employee(s) bring Chain of Custody Form when they present for drug screen? YES or NO
Who do we contact if employee arrives without your chain of custody form in hand?
Name/Contact #_____
_____

Choose Agency: FMCSA FRA FTA PHMSA FAA USCG

Urine Drug Screen/with MRO review _____**DOT** ____**Non-DOT** **(lab based test)**

Breath Alcohol _____**DOT** _____**Non-DOT**

RESULTS – PLEASE SPECIFY WHO NEEDS TO RECEIVE DRUG & ALCOHOL RESULTS AND HOW THEY WANT TO RECEIVE THEM (example: Fax, Email, mail)_____

Panel Choices for Urine Drug Screens

_____**5 Panel** (AMP, COC,OPI,PCP,THC) _____ **7 Panel** (AMP,BAR,BZP,COC,OPI,PCP,THC)

_____**9 Panel** (AMP,BAR,BZP,COC,MTD,OPI,PCP,PPX,THC) _____ **9 Panel** plus extended Opiates + OXY

____**10 Panel** (AMP,BAR,BZP,COC,MTD,MTQ,OPI,PCP,PPX,THC) _____**10 Panel** plus extended Opiates + OXY

____DOT LOOK-ALIKE (AMP,COC,OPI,PCP,THC,MDMA,6-AM, HYDROMORPHONE,OXY)

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DRUG SCREENING FOR ORAL FLUID (SALIVA) & HAIR TESTING (If you have an account set up with another lab and MRO, we can provide collection only services, if so please provide kit and chain of custody to collect. Otherwise our lab LabCorp will used and processed through our MRO.

Oral Fluid (saliva) ____ **5** Panel (AMP,COC,OPI,PCP,THC)

____ 9 Panel (AMP, BAR, BZP, COC, MTD, OPI14, PCP, PPX, THC, OXY)

HAIR ____ **5** Panel (AMP, COC, OPI, PCP, THC)

_____ 9 Panel (AMP, BAR, BZP, COC, MTD, OPI, PCP, PPX, THC)

RESULTS – PLEASE SPECIFY WHO NEEDS TO RECEIVE DRUG & ALCOHOL RESULTS AND HOW THEY WANT TO RECEIVE THEM (example: Fax, Email, mail)_____

- Continued -

DRUG AND ALCOHOL TESTING

Urine collection services only

Velocity UC offers collection services for those employers who have an existing account of their own set up through (**Quest, LabCorp, Alere, CRL, Medtox etc.**) with their Medical Review Officer or a Third-Party Administrator. Indicate the type of test you are requesting:

_____**DOT** Collection Only _____ **NON-DOT** Collection Only

Will your company provide Velocity UC with your compan**y's** Chain of Custody Form in advance? YES or NO

Will your employee(s) bring Chain of Custody Form when they present for drug screen? YES or NO
Who do we contact if employee arrives without chain of custody form in hand?
Name/Contact #_____

Our fee schedule is competitive in the market, a list for all Employer Health Services Fees will be forwarded to you. Please note changes in fees may change based on outside vendors, we will do our best to keep you informed of them. If you should have questions, please contact the below individuals.

PLEASE NOTE-We encourage employers to use our on-line scheduling tool to hold a spot for select employer paid services example: DOT physicals, PPD placements etc. Additional information will be provided upon request.

EMPLOYEES MUST PRESENT EMPLOYER AUTHORIZATION FOR SERVICE AT THE TIME OF VISIT.

NO SHOW FEES may be billed if scheduled appointments are not canceled with 24 hours notice.

We look forward to doing business with your company and supporting the Occupational Health needs of your employees.

Printed Name of Company Representative _____

Signature of Company Representative _____

Date: _____

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