ROCC
REGIONAL OCCUPATIONAL CARE CENTER
A UNITY HEALTHCARE PARTNER

New Company Form – Injury Care

Patient Name: _____
Office use

Date _____

Company Name _____

Address_____
Street City Zip

Phone _____ Contact Person _____

Contact Fax _____

For billing purposes, who is your workers compensation carrier?

Name of insurance: _____

_____

_____

Phone # _____

Fax # _____

Does you company require post accident drug screening? Yes_____ No _____
(If post accident drug screening is requested our lab manager will contact you to verify the type of testing requested)

After the visit, the patient will have what is called a return to work form that is a brief overview of their visit that day. How would you like to obtain a copy of this document:
(please circle)

a) Send back with patient
b) Fax to the following individual _____ Fax # _____

The doctor will then dictate a formal note, or dictation. How would you like to obtain this document? (please circle)

a) Mail to the following individual _____
b) Fax to the following individual _____ Fax # _____

If we need to obtain approval for physical therapy, imaging ext…. do we get approval from your company or your workers compensation carrier? (please circle)

a) Contact the following person for approval _____
b) Contact our insurance carrier for approval

Do you have a preferred pharmacy for your employees to fill their prescriptions?

a) yes: pharmacy name: _____
b) no, any pharmacy will do

May the patient use our non-narcotic medicines? Yes_____ No_____

PLEASE FAX THIS FORM BACK TO ROCC AT 765-446-1083 WHEN COMPLETE
Any questions please call us at 765-446-2450