ROCC
REGIONAL OCCUPATIONAL CARE CENTER
A UNITY HEALTHCARE PARTNER

Thank you for your interest in the services offered by ROCC. Please complete the following form as it applies to your company's needs and return by fax to 765-446-1083. If you have any questions, please do not hesitate to contact Tina Minier at 765-446-5028.

COMPANY NAME _____ **Date** _____

MAIN TELEPHONE _____ **FAX** _____ **EMAIL** _____

ADDRESS _____ **BILL SERVICES TO** _____

_____   _____

_____   _____

CONTACT FOR PHYSICALS _____ **P** _____ **F** _____

CONTACT FOR INJURY CARE _____ **P** _____ **F** _____

CONTACT FOR DRUG SCREEN _____ **P** _____ **F** _____

CONTACT FOR BILLING _____ **P** _____ **F** _____

SERVICES REQUESTED:

Physicals:

☐ DOT   ☐ Pre-Employment   ☐ Basic   ☐ Respirator Physical

☐ Respirator Fit w/OSHA Questionnaire   ☐ PFT

Drug Screens:

☐ Company's Chain of Custody   ☐ ROCC Chain of Custody

Pre-Employment: ☐ DOT   ☐ 5 Panel   ☐ 11 Panel   ☐ Breath Alcohol

☐ Hair Collection   ☐ Nicotine

Post-Accident: ☐ DOT   ☐ 5 Panel   ☐ 11 Panel   ☐ Breath Alcohol

☐ Hair Collection

Random/ Reasonable Suspicion: ☐ DOT   ☐ 5 Panel   ☐ 11 Panel   ☐ Breath Alcohol

☐ Hair Collection   ☐ Nicotine

After Hours Drug Screen / Breath Alcohol Test $250   ☐ YES   ☐ NO

Send results Attn: _____ ☐ Email _____

☐ Fax _____   ☐ Mail _____

Other Services:

☐ Hearing Test w/o Interpretation   ☐ Hearing Test w/ interpretation

☐ Vision Test   ☐ Lift Test

Injections:

☐ Tetanus / Tdap   ☐ Hepatitis ___   ☐ MMR   ☐ TB Screening
                                                       ○ Skin Test ○ Quantiferon ○ Chest XRAY

☐ Varicella   ☐ Flu Shot   ☐ Other _____

Labs:

☐ Hepatitis Titer   ☐ Varicella Titer   ☐ MMR Titer   ☐ Other _____

Work Comp Services:

Carrier _____ Phone _____ Fax _____

Address _____

Authorization for referrals such as Physical Therapy, Imaging, Consults, etc... should come from: ☐ INSURANCE   ☐ EMPLOYER

Who from the employer can authorize referrals: _____ Title_____

Phone _____ Fax _____ Email_____

Send Return to Work paperwork to Attn: _____

☐ Email _____   ☐ Fax _____

☐ Mail _____   ☐ Send with patient

Send Office Notes to Attn: _____

☐ Email _____   ☐ Fax _____

☐ Mail _____

Send Missed Appt Notice to Attn: _____

☐ Email _____   ☐ Fax _____

☐ Mail _____

Do you have a preferred Pharmacy?   ☐ YES   ☐ NO

If Yes, pharmacy name: _____ Phone: _____

May the patient use our non-narcotic medications?   ☐ YES   ☐ NO

Any other special requests or information we should know? _____

_____

_____

_____

_____

_____