WORKNET
Occupational Medicine
managed by NovaCare

Paperwork given _____
Paperwork Rcvd _____
Triaged to rack/bin _____
Medical services start_____

Patient Registration

.

Please Print Clearly

Today's Date: _____/_____/_____ **Social Security #:_____-_____-_____**

First Name:_____ MI:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone: _____ Mobile phone: _____ Email:_____

Consent: ***WORKNET may send my medical information to the email listed above.*** YES ☐ NO ☐

Driver's License or ID #: _____ Date of Birth:_____/_____/_____

Gender: Male ☐ Female ☐

Employer/Potential Employer: _____

By signing below, I acknowledge the following:

1) I hereby give authorization to WORKNET Occupational Medicine to provide me with medical treatment for my work-related injury/illness and/or employment-related physical examination. I understand that employment-related physical examinations are not meant to replace routine health care as provided by my private physician. I also understand that an employment-related examination is often times not a complete evaluation and is being performed solely to evaluate my ability to safely perform the tasks required of me by the job I am applying for or the job I am currently performing.
2) I hereby give WORKNET Occupational Medicine authorization to release to my employer, insurance company, and their representatives any medical information, including any psychiatric and/or HIV related information, which is obtained as part of the treatment for this work related injury/illness, or employment-related physical examination.
3) I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
4) I understand that I may revoke this authorization at any time, except to the extent that action has been taken by WORKNET Occupational Medicine, by providing a written request to the Office where my care was provided.
5) I understand that I am not required to sign this form and medical treatment and/or substance abuse testing will not be withheld as a condition of signing this form.
6) I have been provided the WORKNET Occupational Medicine Notice of Privacy Practices.
7) If you are presenting **ONLY** for a Department of Transportation (DOT) drug and/or alcohol test, you are not required to sign below.

Patient Signature _____Date_____

Witness_____ Date_____

Substance Abuse Testing

If you are here for substance abuse testing at the request of your employer or prospective employer, the results will be sent to the designated employer representative (DER) at the above-mentioned company. A refusal or failure to submit to the requested test(s) at this time may be viewed as a positive test result by your company policy.

Type of Test: ☐ **Urine Drug Test** ☐ **Breath Alcohol** ☐ **Other**_____

Reason for testing: ☐ **Pre-employment** ☐ **Random** ☐ **Post Accident** ☐ **Reasonable Suspicion** ☐ **Return to Duty**
☐ **Follow Up** ☐ **Other** _____

Office Use Only

Substance Abuse Test completed (Collector's Initials): Without incident _____ With Incident_____(Comment)

(rev. 03/2016)