MEDCARE OCCUPATIONAL HEALTH

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PATIENT ID / RECORD # _____

Patient Registration & Consent for Evaluation

FORM MC-100

PATIENT INFORMATION

PATIENT NAME	DRIVER LICENSE #
DATE OF BIRTH	GENDER ☐ Male ☐ Female
HOME ADDRESS	CITY, STATE, ZIP
PHONE #	EMAIL
EMERGENCY PHONE #	BARCODE / CHAIN OF CUSTODY #

REASON FOR VISIT

SERVICES REQUESTED

☐ Urine Drug Test **(UDT)**	☐ Pre-Employment Physical Examination **(PEP)**
☐ Hair Follicle Drug Test **(HFDT)**	☐ DOT Physical Examination **(DOT PE)**
☐ Oral Fluid Drug Test **(OFDT)**	☐ Non-DOT Physical Examination **(NDP)**
☐ Breath Alcohol Test **(BAT)**	☐ HAZWOPER Medical Examination **(HME)**
☐ Random Drug Test **(RDT)**	☐ Firefighter Medical Examination **(FME)**
☐ Blood Collection **(BC)**	☐ Return to Work Evaluation **(RTW)**
☐ Medical Weight Management **(MWM)**	☐ Audiogram / Hearing Test **(AUD)**
	☐ Respirator Fit Test **(RFT)**

CONSENT FOR EVALUATION AND TREATMENT

I hereby consent to receive medical evaluation, treatment, and related occupational health services as deemed necessary by the licensed healthcare provider at MedCare Occupational Health PLLC. I understand that these services are provided for employment and occupational purposes, and that relevant results may be shared with my employer or their designated representative as permitted by law. I acknowledge that care provided by MedCare Occupational Health PLLC does not replace the medical care of my personal physician.

PATIENT SIGNATURE _____ DATE _____