



Client Request for Services - Broussard

Client Information

Company Name		Date
Company Billing Address		
City	State	Zip Code
Employee Name	Job Title	Employee Last 4 SSN/ID#
Testing Authorized By		Phone Number
Send Results To		Email Address
Project Number:		Phase Number:

Testing Location

BROUSSARD 1028 Forum Drive, Broussard, LA 70518 PH: 337-704-0981 Fax: 337-704-0982 xmdcorporateclinic@xtrememd.com

Physical Exam Requested

- | | | |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Annual / Periodic | <input type="checkbox"/> DOT / CDL Physical | <input type="checkbox"/> Non-DOT Physical |
| <input type="checkbox"/> Pre-Employment Standard Non-Dot Physical | <input type="checkbox"/> Fit for Duty
<small>Medical records from treating facility/physician required prior to exam</small> | <input type="checkbox"/> Company Specific Physical
<small>Company specifications / guidelines required 48 hours in advance for review prior to testing</small> |
| <input type="checkbox"/> OGUK Physical | <input type="checkbox"/> USCG Physical | <input type="checkbox"/> Other: _____ |

Occupational Testing Procedures Required

- | | | | | |
|----------------------------------------------------|----------------------------------|---------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> Audiometry | <input type="checkbox"/> Initial | <input type="checkbox"/> Retest | <input type="checkbox"/> Pre-Employment | <input type="checkbox"/> Respirator Fit Testing w/OSHA Resp. Questionnaire |
| <input type="checkbox"/> Blood Work Specify: _____ | | | | <input type="checkbox"/> Mask Type: _____ |
| <input type="checkbox"/> EKG w. Interpretation | | | | <input type="checkbox"/> Fitness Assessment |
| <input type="checkbox"/> Urinalysis / UA Dip | | | | <input type="checkbox"/> Respirator Medical Clearance |
| <input type="checkbox"/> L-Spine X-Ray | <input type="checkbox"/> 3 View | <input type="checkbox"/> 2 View | <input type="checkbox"/> Pulmonary Function Test w/OSHA Resp. Questionnaire | |

Urine Drug and Alcohol Collection: *Applicant Must Bring Valid Photo ID*

Reason for Testing

- | | | | | | |
|---------------------------------------------------|---------------------------------------|-------------------------------------------|----------------------------------------|-----------------------------------------|------------------------------------|
| <input type="checkbox"/> Pre-Employment | <input type="checkbox"/> Random | <input type="checkbox"/> Reasonable Cause | <input type="checkbox"/> Post Accident | <input type="checkbox"/> Return to Duty | <input type="checkbox"/> Follow-up |
| <input type="checkbox"/> Site Access / Pre-Access | <input type="checkbox"/> Other: _____ | | | | |

Drug Collection

- | | | | | | | |
|----------------------------------------------------------------------------|-------------------------------------------------------|--|------------------------------------------------------|----------------------------------------------------|-------------------------------|--------------------------------|
| <input type="checkbox"/> Non-DOT UDS | | | | <input type="checkbox"/> PHMSA | <input type="checkbox"/> USCG | <input type="checkbox"/> FMCSA |
| <input type="checkbox"/> Hair Follicle | | | | | | |
| <input type="checkbox"/> DOT UDS | | | | | | |
| <input type="checkbox"/> Rapid Urine Dip | | | | <input type="checkbox"/> 10 Panel | | |
| <input type="checkbox"/> Customer Supplied Chain of Custody | | | | <input type="checkbox"/> Third Party Administrator | | |
| <input type="checkbox"/> Use XMD Generic Chain of Custody (\$75.00) | | | | | | |
| <input type="checkbox"/> 5 Panel UDS | <input type="checkbox"/> 9 Panel UDS | | <input type="checkbox"/> 10 Panel UDS | | | |
| <input type="checkbox"/> Direct Observation | | | | | | |
| <input type="checkbox"/> Synthetic Drug Testing
(Generic XMD CCF Codes) | <input type="checkbox"/> Synthetic Marijuana (30380N) | | <input type="checkbox"/> Synthetic Stimulants (280N) | | | |

Alcohol Collection

- | |
|----------------------------------------------------|
| <input type="checkbox"/> DOT Saliva (QED) Swab |
| <input type="checkbox"/> Non-DOT Saliva (QED) Swab |
| <input type="checkbox"/> DOT BAT |
| <input type="checkbox"/> Non-DOT BAT |

COVID-19 Testing

- PCR Antigen



