

Urgent Care & Occupational Medicine Clinic Initial Visit Information Form

Patient Information - Workers Compensation

(please fill out completely)

DOI: _____ Type of Injury _____

Name of Injured Worker: _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell/Work Phone _____

Birth Date _____ Social Security # _____

Medication Allergies _____

Employer Name: _____

Employer Address: _____

City _____ State _____ Zip _____

Employer's Phone: _____ Contact Name _____

Employer's Fax: _____

Employer's Worker's Compensation Carrier: _____

Do You Require A Urine Drug Screen? Yes No

Treatment Authorized By: _____

Release of Information:

I certify that this claim is specifically due to a Workers' Compensation injury and I authorize the release of any and all of my claim files and records to CSHP Pharmacy and Stone River Pharmacy Solutions.

Signature

Date

www.cshp.net

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CSHP

COLORADO SPRINGS HEALTH PARTNERS, P.C.