# 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

CSHP
COLORADO SPRINGS HEALTH PARTNERS
A DaVita Medical Group

www.cshp.net