PLANO URGENT CARE

**Work-Related Injury**

To be completed by Patient or Supervisor:

| | |
|---|---|
| ***Today's Date:** | ***Date of Injury:** |
| ***Patient:** | *Injury Description: |
| Birthday: | SSN: __ __ __ - __ __ - __ __ __ __ |

To be completed by Employee Supervisor/DER: (initials:_____)

| | |
|---|---|
| *Company: | *Job Description: |
| Address: | City, State: |
| *Supervisor/HR contact: | |
| ***Phone:** | Fax: |
| *Bill to: | **WC Contact Name:** |
| **WC Insurance:** | **Network** (if known): |
| **Claim#**: | **WC Contact #:** |

| ***Will incident testing be required for this visit?** Yes / No (if 'yes' – must select from below) | | | |
|---|---|---|---|
| | Non-DOT Urine Drug Screen - rapid test onsite, 11 panel test | | DOT, Urine Drug Screen |
| | Non-DOT Drug Screen – collect & send only | | DOT, Breath Alcohol |
| | Non-DOT Breath Alcohol | | |
| ***Reason for Test:** Pre-Employment \| Random \| Post-Accident \| Reasonable Susp. Return to Duty \| Follow-up | | | |

| * Where do we send Medical Record, Test Results & Return to Work Forms: |
|---|
| __**FAX** (must be private/secure)**:** |
| __**Email:** _____ |

| **Other Instructions:** |
|---|
| |

**Plano Urgent Care** **(469) 443-0275** **www.PlanoUC.com**

901 W. 15th Street, Plano TX, 75075

**Hours**

Mon-Fri: 9am – 9pm

Sat/Sun: 9am – 6pm