2100 Franklin Street, Suite 355
Oakland, CA 94612

**Carbon Health**

CarbonHealth.com
OccHealth@carbonhealth.com

***REMINDER: Please fill out the appropriate organization / responsible party***

## Treatment Authorization Form

**Patient Name:** ______________________

**DOB:** ___/____/___ **Date:** ____/_____/_____

**Organization:** Southeast Ventura County YMCA

**Tel:** 805-583-5338 ext 4012 **Fax:** ______________________

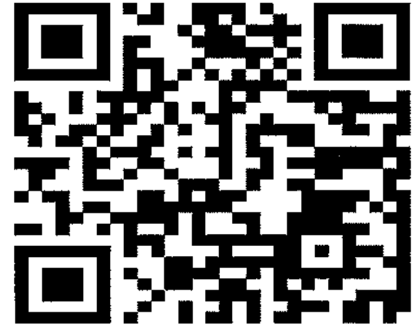
**Email:** jgonzalez@sevymca.org

*Authorized by:*

**Name:** Jaime Gonzalez **Title:** Director of Culture and Engagement

**Signature:**

Book your appointment: Scan QR code or https://crbn.app.link/e/workplace-health



*Please bring a Photo ID to your appointment*

**Services Requested (check all that apply):**

**Workers Compensation** *(Select "Workplace Injury" visit type)*

- ☐ *Please check if you are providing authorization to treat for workplace injury*

Carrier: ______________________

Claim #: ______________________

Policy No: ______________

Direct Bill? _____ (not available in CA)

Date of Injury: ___/___/____

Reason for visit: ______________________

Notes: ______________________

**Drug & Alcohol Testing** *(Select "Drug Test" visit type)*

- ☐ 4 Panel Drug Screen (NJ only)
- ☐ 5 Panel Drug Screen Send Out (Carbon Lab / Forms)
- ☐ 10 Panel Drug Screen Send Out (Carbon Lab / Forms)
- ☐ Breath Alcohol Testing (DOT) (NJ, CA, OH, PA only)
- ☐ Breath Alcohol Testing (Non DOT) (NJ, CA, OH, PA)
- ☐ Non DOT Drug Screen Collection Only
- ☐ DOT Drug Screen Collection Only
- ☐ 5 Panel Rapid / Express Drug Screen
- ☐ 10 Panel Rapid / Express Drug Screen

**Tuberculosis Testing** *(Select "General Health" visit type)*

- ☑ TB Skin Test
- ☐ QuantiFERON (TB Blood test)
- ☐ Chest X-Ray (Single View, PA) - For R/O TB

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**Radiology** *(Select "General Health" visit type)*

- ☐ Chest X-Ray (Single View, PA)
- ☐ Chest X-Ray (PA & Lateral)

**Physical Examinations** *(Select "Basic Physical" or "DOT Physical" visit type as relevant)*

- ☐ DOT Physical
- ☐ OSHA Questionnaire (Clear to FIT)
- ☑ Pre-employment Physical (Occ Health Physical)
- ☐ FIT For Duty (NJ only)
- ☐ NFPA / AME (Circle one) (NJ only)
- ☐ COVID Eval + Antigen / PCR (Circle one)
- ☐ Human Performance Evaluation (NJ only)
- ☐ Lift Assessment (NJ only)

**Audio, Vision, Lung Capacity Screening** *(Select "General Health" visit type)*

- ☐ Audiometry
- ☐ Ishihara (Color Blindness)
- ☐ Spirometry (NJ only)
- ☐ Qualitative Respirator FIT
- ☐ Quantitative Respirator FIT (Somerset, NJ only)
- ☐ Vision (Snellen)

**Titers** *(Select "General Health" visit type)*

- ☐ Titer - Hep A
- ☐ Titer - Mumps
- ☐ Titer - Hep B
- ☐ Titer - Rubella
- ☐ Titer - Measles
- ☐ Titer - Varicella

**Vaccinations** *(Select "General Health" visit type)*

- ☐ Vaccine - Hep A & B
- ☐ Vaccine - Influenza
- ☐ Vaccine - TDAP (TD + Pertussis)
- ☐ Vaccine - Hep A Adult
- ☐ Vaccine - Tetanus/Diphtheria
- ☐ Vaccine - Hep B Adult
- ☐ Vaccine - MMR

**Laboratory Testing & Analysis** *(Select "General Health" visit type)*

- ☐ Comprehensive Metabolic Panel
- ☐ Complete Blood Count
- ☐ Lead Blood Levels
- ☐ Finger Stick - Glucose
- ☐ Urinalysis

*Looking for services not listed here? Please email occhealth@carbonhealth.com prior to sending your employees.*

# HEALTH SCREENING REPORT - FACILITY PERSONNEL

*All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.*

***A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.***

FACILITY NAME

FACILITY ADDRESS

| PERSON'S NAME | | AGE | |
|---|---|---|---|
| POSITION TITLE | TYPE OF FACILITY | WORK DAYS PER WEEK | WORK HOURS PER DAY |

DUTY STATEMENT

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☐ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☐ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* ____________________

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

| SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE | ADDRESS | DATE |
|---|---|---|
| ▶ | | |

**NOTE TO PHYSICIAN:** *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

| DATE OF T.B. TEST | ☐ POSITIVE ☐ NEGATIVE | ACTION TAKEN (IF POSITIVE) | |
|---|---|---|---|
| DATE OF HEALTH SCREENING | NAME OF PHYSICIAN (PHYSICIAN'S STAMP) | | DATE |

| **HEALTH SCREENING BY: (ORIGINAL SIGNATURE)** | **TELEPHONE #** | **DATE** |
|---|---|---|
| ▶ | | |