MEDXCEL
OCCUPATIONAL MEDICINE & WALK-IN CLINIC
106 Heritage Parkway; Broussard, LA 70518
Phone: 337-856-7500 Fax: 337-856-7502

Please Print

Last name: _____ First name:_____ Age:_____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth: _____ SSN: _____ Race: _____ Marital Status: _____

Home Phone: _____ Company Name: _____ Title: _____

Have you ever been seen at MedXcel LeTriomphe before? Yes or No

Consent for services

I hereby consent to medical evaluation and/or treatment provided to me by the staff of MedXcel. I authorize MedXcel to disclose to my employer and/or its designated insurance carrier any information concerning my condition including the history and the physical, all laboratory reports and all x-ray reports. I hereby release MedXcel and its employees from any liability arising from such disclosure.

Signature_____ Date_____

Consent for drug and/or alcohol testing

I hereby consent to provide a urine sample, breath sample, and/or hair sample for the purpose of performing any testing necessary, by a laboratory chose by my employer/potential employer, to determine the presence and/or level of drugs and/or alcohol in my body. I further give MedXcel my consent to release to the proper company representative of _____ (company name) the results of my drug and/or alcohol testing. I understand that these results may be used to determine any fitness for employment or continued employment with this company.

Signature_____ Date_____

REQUIRED	SERVICE	COMPLETE	REQUIRED	SERVICE	COMPLETE
	PHYSICAL EXAMINATION			OSHA LEAD LEVELS WITH ZPP	
	SHORT PHYSICAL			ZINC	
	DOT PHYSICAL			PSA	
	PULMONARY FUNCTION TEST			HIV	
	ELECTROCARDIOGRAM			LIVER PANEL	
	AUDIOGRAM			CHOLESTEROL	
	HAIR TEST			URINALYSIS	
	5 PANEL QUICK TEST			TUBERCULOSIS TEST	
	9 PANEL QUICK TEST			CXR 1 VIEW	
	NON-DOT DRUG SCEEN			CXR 2 VIEW	
	DOT DRUG SCREEN			LUMBAR XRAY 3 VIEW	
	BREATH ALCOHOL TEST			LUMBAR XRAY 5 VIEW	
	CBC, CMP, LIPID PROFILE			LIFT TEST	
	OCCULT BLOOD			HGbA1c	
	RESPIRATOR FIT TEST			ACCU CHECK	
	VISION TEST				

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Name: _____ SSN: _____ DOB: _____

Company: _____ Job title: _____

I. MEDICAL HISTORY: (PLEASE ANSWER EVERY QUESTION)

A. Have you ever had:

YES	NO		YES	NO		YES	NO		YES	NO	
____	____	Cancer	____	____	Schizophrenia	____	____	Emphysema	____	____	Back trouble
____	____	Allergies	____	____	Depression	____	____	High blood pressure	____	____	Urinary bladder trouble
____	____	Hay fever	____	____	Bipolar disorder	____	____	Heart murmur	____	____	Kidney trouble
____	____	Hives	____	____	Anxiety attacks	____	____	Hepatitis	____	____	Prostate trouble
____	____	Poor vision	____	____	Atopic dermatitis	____	____	Peptic ulcer	____	____	Migraine headaches
____	____	Glaucoma	____	____	Psoriasis	____	____	Colitis	____	____	Epilepsy
____	____	False teeth	____	____	Fungal infection	____	____	Hemorrhoids	____	____	Stroke
____	____	Rhinitis	____	____	Yeast infection	____	____	Hernia	____	____	Motion sickness
____	____	Broken bone	____	____	Tuberculosis	____	____	Arthritis	____	____	Sea sickness
____	____	Diabetes	____	____	Chronic bronchitis	____	____	Pancreatic disease	____	____	Other sickness
____	____	Thyroid trouble	____	____	Asthma	____	____	Ruptured disc			

B. Do you presently have:

YES	NO		YES	NO		YES	NO		YES	NO	
____	____	Fever	____	____	Frequent headaches	____	____	Skin sores	____	____	Blood in stool
____	____	Tire easily	____	____	Numbness	____	____	Productive cough	____	____	Dark urine
____	____	Weight loss	____	____	Tingling anywhere	____	____	Dry cough	____	____	Burning on urination
____	____	Flushing	____	____	Fits/Seizures	____	____	Chest pain	____	____	Wake up to urinate
____	____	Frequent infections	____	____	Tremors	____	____	Wheezing	____	____	Leg pain from walking
____	____	Runny nose	____	____	Dizziness	____	____	Shortness of breath	____	____	Weak in arms or legs
____	____	Sore throat	____	____	Get angry easily	____	____	Wake up short of breath	____	____	Back pain
____	____	Light headed	____	____	Nervousness	____	____	Nausea and vomiting	____	____	Joint stiffness
____	____	Eye trouble	____	____	Depression	____	____	Loose stools	____	____	Trouble sleeping
____	____	Swelling around eyes				____	____	Yellow eyes	____	____	Abdominal pain
____	____	Bags under eyes				____	____	Itching	____	____	Rash

YES	NO	
____	____	A. Have you ever had any low back injuries or trouble with your low back? _____
____	____	B. Have you ever had any major injury? _____
____	____	C. Do you take routine medication; prescription or over the counter? If yes, list: _____
____	____	D. Are you allergic to any medication? If yes, list: _____
____	____	E. Have you ever had surgery? If yes, list: _____
____	____	F. Have you ever had a tetanus injection? If yes, when was your last injection? _____

II. SOCIAL HISTORY

____ ____ A. Do you use tobacco products? If yes, what type and how much? _____

____ ____ B. Do you drink alcohol? If yes, how much per week? _____

III. OCCUPATIONAL HISTORY

A. What is your usual occupation/trade? _____

B. How many pounds were you required to lift on your last job? _____

____ ____ C. Are you capable of frequently lifting 100lbs.? If, no how much can you lift? _____

____ ____ D. Have you ever had any injury or illness arising out of your employment? _____

NOTICE: YOUR FAILURE TO ANSWER TRUTHFULLY ANY QUESTIONS ABOUT PREVIOUS INJURIES, DISABILITIES, OR OTHER MEDICAL CONDITIONS MAY RESULT IN FORFEITURE OF WORKERS COMPENSATION BENEFITS UNDER LSA R.S. 23:1208.1. I ACKNOWLEDGE THAT I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND I HAVE READ AND UNDERSTAND THE ABOVE NOTICE;

Signature: _____ Date: _____

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Name: _____ Date: _____

REVIEW OF HISTORY:

_____
_____
_____
_____

Ht: _____ Wt: _____ BP: _____ P: _____ Temp: _____

Vision: Uncorrected: Far Near Corrected: Far Near

RIGHT	20/	20/	RIGHT	20/	20/
LEFT	20/	20/	LEFT	20/	20/
BOTH	20/	20/	BOTH	20/	20/

Color Vision: Normal Abnormal
Depth perception: Normal Abnormal
Peripheral Vision: Normal Abnormal

Laboratory: Urinalysis: SpGr_____ Alb_____ Glu_____ Bld_____ Nitrate _____ Leu _____ CBG (if needed) _____
X-rays: CXR: _____ Back X-ray: _____

PHYSICAL EXAMINATION:

	Normal	Abnormal
General		
Skin		
HEENT		
Chest		
Heart		
Abdomen		
Anus/Rectum		
Genitals		
Hernia		
Extremities		
Neurological		
Back		

No significant abnormalities: _____
Abnormalities: _____
_____
_____
_____

_____ Employable-no accommodations
_____ Employable with accommodations
_____ Qualified for respirator/SCBA
_____ Employable-no accommodations pending drug screen/X-ray/laboratory
_____ Medical Hold
_____ Hearing protection required
_____ Does not meet job requirements even with accommodations
_____ Corrective eyewear required

I authorize the release of this information to the company

_____ _____
Signature of Applicant

☐ David Silar, M.D. ☐ Chet Stelly, FNP-C
☐ Marissa Guidry, FNP-CC

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MEDICAL RECOMMENDATION FORM

Name: _____ Date: _____

Company: _____ Job Title: _____

Examination:

- ☐ Pre-placement
- ☐ Hazmat Examination
- ☐ Dot Driver Examination
- ☐ Other

The following medical recommendation is based on a review of the history, physical examination and any ancillary test. This recommendation is for the specific job title listed above.

Status:

- ☐ Employable without accommodations.
- ☐ Employable without accommodations pending drug screen/x-ray/lab work.
- ☐ Employable with accommodations if accommodations are available.
- ☐ Medical hold.
- ☐ Does not meet job requirements even with accommodations.

Special Status:

- ☐ Corrective eyewear is required.
- ☐ Hearing protection is required.
- ☐ Employee is medically qualified to wear a respirator.
- ☐ Employee is medically qualified to wear a self-contained breathing apparatus (SCBA)

I have been informed of all medical findings and authorize the release of the history, physical exam and test results to the company.

_____ _____

Signature of applicant/employee

- ☐ David Silar, M.D.
- ☐ Chet Stelly, FNP-C
- ☐ Marissa Guidry, FNP-C

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAFEFULLY.

Your health information is private. Keeping the privacy of your health information is important to us. This notice describes how we use your personal health information, what your rights are, and what our responsibilities are.

REASONS THAT YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED

- **For treatment:** MedXcel is allowed to use and disclose your protected health information in order to treat you. For example, doctors, nurses, medical technicians and other staff may discuss your case with other health care providers in order to treat you.
- **For payment:** MedXcel is allowed to use and disclose your protected health information in order to get payment for your treatment. For example, MedXcel may disclose the type of treatment provided to you in order to get payment from an insurance company. Your information may also be shared with other government programs such as Medicaid and Medicare to coordinate benefits.
- **For health care operations:** MedXcel is allowed to use and disclose your protected health information in order to continue its health care operations. For example, your information may be used or disclosed by a nurse to a social worker for case management purposes and care coordination with other providers of service who may be involved in your case. Your information may be used to review and evaluate our performance in providing services.
- **Appointment reminders:** MedXcel may use your protected health information to contact you to remind you about your appointments, to give you information on treatment alternatives and to provide you with information on other health related benefits and services.
- **Business Associates:** There are some services provided by MedXcel through contracts with businesses. Examples include health care providers and consultants. When these services are agreed upon, we may share your health information with these businesses so that they can perform the job we have asked them to do. To protect your health information we required the business associates to keep your information private.
- **Research:** Anyone that would like to use personal health information to conduct research studies much have approval of the institutional review board unless restricted by other federal and state laws. Only after approval MedXcel may disclose your information.
- **The Country Administrator:** MedXcel is permitted to share your personal health information with the Country Administrator, who is responsible for overseeing mental health services and much receive information regarding MedXcel's mental health operations as required in certain circumstances as permitted by law.
- **Commitment proceedings:** During the course of an involuntary commitment proceeding, the judge may direct that the court, or mental health review officer, as allowed under the Mental Health Procedures Act, have access to your personal health information for purposes of conduction the hearing. If you are the subject of an involuntary commitment proceeding, information will be shared with attorneys assigned to represent you.
- **Food and Drug Administration (FDA):** MedXcel may disclose health information to the FDA about problems with food, supplements, product and product defects, or post marketing surveillance information so that the FDA may call for product recalls, repairs, or replacements.
- **Workers Compensation:** MedXcel may disclose health information as authorized by law to comply with laws relating to workers compensation or other similar programs established by law.
- **Public Health:** As required by law, MedXcel may disclose your health information without your consent to public health or legal authorities whose job is preventing or controlling disease, injury or disability.

- **Correctional Institutions:** Should you be an inmate of a correctional institution, MedXcel may share your health information with the health care professionals at the institution so you can continue your health treatment. MedXcel may disclose the protected health information of anyone we reasonably believe that is a victim of abuse, neglect, or domestic violence to the appropriate authorities when authorized by the law.
- **Health oversight activities:** MedXcel may disclose your protected information to a health oversight agency when necessary for the oversight of the health care system, government benefit programs, and to determine compliance with civil rights laws.
- **Judicial and Administrative proceedings:** MedXcel may disclose protected health information in response to a court order, subpoena or other lawful request.
- **Law Enforcement:** In certain circumstance MedXcel may disclose protected health information to law enforcement officials.
- **Decedents:** Your Health information may be used and disclosed to coroners, medical examiners, and funeral directors if it is needed to carry out their duties.
- **Military:** MedXcel may use and disclose protected health information to the appropriate authorities for military and veterans activities.
- **Reports:** Federal law allows your health information to be given to an appropriate health oversight agency, public health authority or attorney, provided that an employee or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially hurting individuals, workers or the public.
- **Required by law:** MedXcel may use or disclose your protected health information for purposes required by law.

When the situation is not an emergency and you have not objected, MedXcel may disclose your protected health information:

- To a relative or someone who you have agreed to be involved in your care or health care payment;
- To notify or assist in notifying a family member or personal representative of your location and general condition;
- To legally authorized disaster relief agencies to coordinate with such agencies.

- **Authorizations:** Other uses and disclosures of your personal health information will be made only with your authorization. You have a right to change your mind at any time in writing before we have shared your information.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION

- You have the right to:
  - Receive private communications of protected health information;
  - Look at and copy your protected health information;
  - Amend your protected health information;
  - Receive a paper copy of this notice upon request;
  - Ask that your protected health information not be shared in certain circumstances. MedXcel is not legally required to agree to your request.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Office in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our privacy practices.

Print Name: _____

Signature: _____

Date: _____