Primary Health Medical Group
Occupational Health Program

Treatment Referral Form

Company Info:

Company:_____

Address:_____

Contact:_____Phone:_____Fax:_____

Employee Info:

Employee Name:_____

SS# or ID #:_____

Services to be performed today (check all that apply):

☐ Drug Screen Collection
- ☐ Non-DOT
- ☐ DOT**

☐ Breath Alcohol Test [Nampa, Crossroads, Broadway]
- ☐ Non-DOT
- ☐ DOT**

☐ Other_____

****Please tell us which Federal AGENCY to test for:**

☐ HHS DOT: ☐ FMCSA ☐ FTA ☐ FAA ☐ FRA ☐ PHMSA

Why is your employee being tested?

☐ Pre-Employment ☐ Random ☐ Post-Accident ☐ Reasonable Suspicion ☐ Return to duty ☐ Follow Up

Location Requested

☐ **OVERLAND-**8971 W Overland Boise, ID
P-208-378-4288 F-378-4297

☐ **BROADWAY**-1907 S Broadway Ste 101 Boise, ID
P-208-345-1222 F-345-1261

☐ **NAMPA**-700 Caldwell Blvd Nampa, ID
P-208-466-6567 F-208-466-7922

☐ **STATE ST**-6052 W. State St.
P-208-344-7799 F-208-344-7152

☐ **CROSSROADS**-3115 E Florence Meridian, ID
P-208-895-8670 F-208-955-0494

☐ **EAGLE**-435 South Eagle Rd Eagle, ID
P-939-8200 F-939-8222

☐ **CALDWELL**-1825 Kimball Ave Caldwell, ID
P-208-455-3545 F-208-454-9690

☐ **Meridian**-1130 E Fairview Meridian, ID
P-208-888-9393 F-208-888-9525

☐ **West Boise-**10787 W Ustick Boise, ID
P-208-378-8011 F-208-322-8095

Special Instructions

Authorized by: _____

Date: _____