



# EXAMINATION MANAGEMENT SERVICES, INC.

## SUPPLEMENTAL SERVICES

lead and innovate

APPLICANT \_\_\_\_\_

COMPANY \_\_\_\_\_

D.O.B. \_\_\_\_\_ DL# \_\_\_\_\_ / \_\_\_\_\_  
State

COMPANY # \_\_\_\_\_ Policy# /File# \_\_\_\_\_  
(Circle One)

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

District/Agency \_\_\_\_\_

Time of Service \_\_\_\_\_ AM/PM

Name of Agent \_\_\_\_\_

Address of Service \_\_\_\_\_

Place of Service \_\_\_\_\_ Residence \_\_\_\_\_ EMSI Office

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business \_\_\_\_\_ Outside Facility \_\_\_\_\_

### SERVICES COMPLETED

#### AMPLIFIED COLLECTION SERVICES/RECHECK

BLOOD PRESSURE (check box if performed)

	Left	Right	Left	Right
SYSTOLIC				
DIASTOLIC				

PULSE RATE PER MINUTE (check box if performed)

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Height (in shoes) \_\_\_\_\_ ft. \_\_\_\_\_ in.  
Repeat if over 90

Weight (in indoor clothing) \_\_\_\_\_ lbs.  
No. of irregularities/Min

#### Males Only

Chest ( Full Inspiration) \_\_\_\_\_ in

Chest (Forced Expiration) \_\_\_\_\_ in

Abdomen at Umbilicus \_\_\_\_\_ in

URINALYSIS (check box if collected, if not, comments in remarks)

Lab  HORL  LabOne  CRL  GIB  Other

For HOS dipstick customer  
Albumin \_\_\_\_\_ Glucose \_\_\_\_\_

Specific Test (If requested) \_\_\_\_\_

BLOOD DRAW (Venipuncture) Site \_\_\_\_\_  
Specific test (if requested) \_\_\_\_\_  
Lab  HORL  LabOne  CRL  GIB  Other

FINGERSTICK (DBS/Micro)  
Lab  HORL  LabOne  CRL  GIB  Other

RESTING EKG

TREADMILL EKG

X-RAY

HOS For HOS dipstick customers  
Albumin \_\_\_\_\_ Glucose \_\_\_\_\_  
Lab  HORL  LabOne  CRL  GIB  Other

TIMED VITAL CAPACITY/TVC

	<u>Actual Values</u>		<u>FEV</u>
Test	1. <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters		<input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters/1 Sec.
	2. <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters		<input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters/1 Sec.
	3. <input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters		<input type="checkbox"/> . <input type="checkbox"/> <input type="checkbox"/> Liters/1 Sec.

Predicted Values

Sex  M  F FVC  .   Liters

Height \_\_\_\_\_ inches FEV1  .   Liters/1 Sec.

If chart produced, is chart enclosed? \_\_\_\_\_

SPECIAL QUESTIONNAIRE \_\_\_\_\_  
(Type)

ATTENDING PHYSICIAN STATEMENTS/APS  
1. Dr. \_\_\_\_\_ Date Ordered \_\_\_\_\_  
2. Dr. \_\_\_\_\_ Date Ordered \_\_\_\_\_

PERSONAL HISTORY

BRANCH OFFICE STAMP

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

Examiner's Printed Name \_\_\_\_\_