

U.S. Healthworks
MEDICAL GROUP

U.S. HealthWorks of Texas
17410 Northwest Freeway
Houston, TX 77040
(713) 466-0044

VISIT SUMMARY

May 25, 2016

NOT IN SYSTEM
NIS
NIS, TX 77054

Attn:
Phone: (999) 999-9999

DAMREL, ASHTON STEPHEN (401-515219)

DOB: 9/02/1996 SSN: XXX-XX-4410

Date of Visit: 5/25/2016
Check-In Time: 03:03p
Discharge Time: 03:50p

Date of Tests: 5/25/2016

EXAMINING PHYSICIAN

SARDANA, JASMINE S., M.D.

PROTOCOLS

PHY/AUDIO/VISION/INSTANT

TESTS

Based on the information provided to me by the employer concerning the tasks inherent to the position, as well as the medical findings, I find that the aforementioned individual is capable of performing the required tasks of the work position that has been offered. The preceding classification is based on available information and is subject to the accuracy and depth of the essential job functions.

SUMMATION:

Any attached information on medical conditions should be treated as confidential medical information in accordance with Section 102C of the AMERICANS WITH DISABILITIES ACT.



REC

NOT IN SYSTEM
Applicant/Employee DOS: 5/25/16
Employer: _____ Patient: DAMREL, ASHTON STEPHEN
Position Title: _____ Case #: 401-515219 Ref #: MA
8321 H

Considering any job-related information provided to me by the employer, either before or upon my request during the course of my evaluation, it is my opinion, that based on the results of the:

- Physical Examination
- Physical Agility Testing
- Other:

The aforementioned individual is:

- Medically acceptable for the position offered.
- Medically acceptable for the position offered, except that a condition exists which limits work as follows: *

- Free of communicable diseases at this time, detectable by a general physical exam and the results of any laboratory tests obtained.
- Placed on medical hold pending:

- Other:

PHYSICIAN:

Signature: _____
Name: _____
Date: 9/29/16

* In compliance with the Americans with Disabilities Act, the medical examiner may **not** list this form either medical diagnoses or conditions. Only restrictions and/or job-related tasks that cannot be adequately performed by the applicant/employee are to be listed.



NOT IN SYSTEM

DOS: 5/25/16

Patient: DAMREL, ASHTON STEPHEN

Case # : 401-515219 Ref # : MA

8321 H
GENERAL PHYSICAL EXAMINATION /
KÁMEN FÍSICO GENERAL
EXAM / EXÁMEN

Name: _____

Date of Exam: _____

Date of Birth: _____

MA/ NURSE NOTES

VITAL SIGNS: Ht: 5' 11" in Wt: 145 lbs Pulse: 74 /min BP: 130/78 mmHg Resp: 14 /min Temp: 98.5° F

VISION: Distant: OD: 20/20 OS: 20/20 OU: 20/20 Near: OD: OS: OU: Corrected: Glasses / Contacts

Color Vision: Normal Abnormal Depth Perception: Normal Abnormal Peripheral Vision: Normal Abnormal

AUDIOMETRY: Normal Abnormal Not done

Completed by: Ana

PHYSICAL EXAMINATION	Normal	Abnormal	Not Examined	Explain Abnormalities
1. GENERAL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. CONSTITUTIONAL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. EMOTIONAL STATUS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. SKIN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. LYMPHATICS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. HEAD / NECK	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. EYES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. EARS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. NOSE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. MOUTH / TONGUE / THROAT	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. TORSO	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. RESPIRATORY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. CARDIOVASCULAR	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. ABDOMEN	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. HERNIA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. UPPER EXTREMITIES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. BACK / SPINE	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. LOWER EXTREMITIES	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. NEUROLOGICAL	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
TESTS	Normal	Abnormal		
21. CBC	<input type="checkbox"/>	<input type="checkbox"/>		
22. Blood Chemistry	<input type="checkbox"/>	<input type="checkbox"/>		
23. Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>		
24. Serology	<input type="checkbox"/>	<input type="checkbox"/>		
25. PFT	<input type="checkbox"/>	<input type="checkbox"/>		
26. Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>		
27. Lumbar X-ray	<input type="checkbox"/>	<input type="checkbox"/>		
28. EKG	<input type="checkbox"/>	<input type="checkbox"/>		
29. Urinalysis Dip.	<input type="checkbox"/>	<input type="checkbox"/>		
SG: 1020 Protein: neg Blood Sugars: Ketone				
30. Other				

PHYSICIAN ASSESSMENT

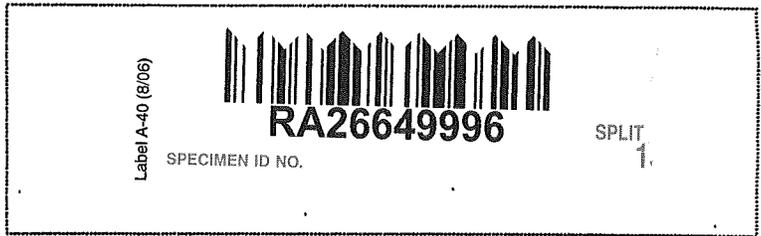
Considering any job-related information provided to me by the employer, before or upon my request during the course of this evaluation, it is my opinion, based on the results that the aforementioned individual is:

- Medically acceptable for the position offered
- Medically acceptable for the position offered, except that a condition exists which limits work as follows:

EXAMINER: Signature: _____
Address: _____

Name: _____ Date: 5/25/16
Telephone: _____

U.S. HealthWorks
 MEDICAL GROUP
MEDTOX INSTANT
DRUG SCREEN
 Consent and Report Form



Medtox Account Code: X (See checked test code below)

Specialty Stea AS/400
 NOT IN SYSTEM 8321 H

DONOR INFORMATION

Name: _____
 Address: _____
 Tel: () _____
 Patient: DAMREL, ASHTON STEPHEN
 Case # : 401-515219 Ref # : MA
 Date of Birth: _____
 State: _____ Zip Code: _____
 Donor Identification: Photo Supervisor: _____ Other: _____
 Reason for Test: Pre-Employment Post Accident Reasonable Suspicion Random Other _____

CONSENT AND RELEASE

I hereby give my consent to and authorize the U.S. Healthworks staff and its designated laboratory to perform any testing necessary to determine the presence and/or level of drugs in my body on behalf of my prospective/current employer, whose name I entered above. I further give my consent for U.S. Healthworks to release any and all results to the aforementioned employer. I agree to hold harmless all U.S. Healthworks employees, physicians, and agents involved in the performance of the testing, from any action that may arise from the disclosure of such test results to the aforementioned employer/prospective employer.

Donor Signature: *Ashton Damrel*

TEST / SPECIMEN INFORMATION

Batch #: 601677 Lot #: 3855 Expiration Date: 9-30-17
 Specimen was examined within 4 minutes. Temperature: 98° °F Physical characteristics: Normal Abnormal
 Second specimen was collected: Temperature: _____ °F Physical characteristics: Normal Abnormal
 Internal Control: Valid Invalid

Remarks: _____

TECHNICIAN CERTIFICATION

I certify that the specimen provided to me by the Donor and identified on this form was collected, labeled, sealed in the Donor's presence, released to (Delivery Service Name) _____ for transport to the laboratory for further testing.
 Collection Facility: US Healthworks Phone: 713-4660044 Fax: 713-4660107
 Name: Ana Triguera Signature: *Ana Triguera* Date: 5-25-16 Time: 4:00pm

DONOR CERTIFICATION

I certify that I provided my urine specimen to the collector; that I did not adulterate it in any manner; that the specimen bottle used was sealed in my presence with a tamper-evident seal; and that the information provided on this form and on the tamper-evident specimen seal is correct.
 Donor Signature: *Ashton Damrel* Tel: (832) 319 0060 Date: 5/25/16

TEST RESULTS

Negative drug screen.
 Specimen (minimum 30 mL) forwarded to lab for further testing.
 5 Panel Acct # 80602162 10 Panel Acct # 80602262
 Donor unable to provide sample within 3 hours.
 Donor refused to be tested.

Reported to: Name: _____ Date: _____ Time: _____ Via: Tel Fax Other: _____
 Reported by: Name _____ Signature: _____

FOR LABORATORY USE ONLY

Received by Accessioner (Name): _____ Signature: _____ AM PM
 Specimen Bottle Seal Intact: Yes No Remarks: _____
 Specimen Bottle Released to: _____



AU1

Name (Nombre): Ashton Stephen Damari Date (Fecha): 5/25/16

Age (Edad): 19 Date of Birth (Fecha Nacimiento): 09/02/1996

Employer (Empleador): Specialty Steel Supply Job Title (Posición): Warehouse Assistant Shophand

Hours since last exposed to loud noise? (¿Hace cuántas horas estuvo expuesto a ruidos fuertes por ultima vez?) 1 month ago

Type of hearing protective devices. (Tipo de protectores auditivos): N/A

AUDIOTRAGRAM RESULTS

TIME/DATE 15:17 05-25-16

EMP NAME

ID NUMBER- 633-54-4410

DOB 09-02-96 SEX- M

TYPE TEST: Annual

DEPARTMENT

SHIFT.....TWA

MI-7000 AUDIOMETER
SERIAL NUMBER: 70210
CALIBRATED ON: 03-08-16
USING ANSI S3.6-1996
EXAMINER CERT #: 000000

FREQ	THRESHOLDS	
	LEFT	RIGHT
500	05	10
1K	00	05
2K	00	05
3K	10	10
4K	15	20
6K	00	10
8K	05	15
1KR		05

2, 3, & 4K AVG 08
ELAPSED TIME 5:03
ROOM NOISE MEETS IBL D1 (Y..N..)

REPORT BELOW								
ESHOLDS								
RIGHT EAR								
F	100	500	1000	2000	3000	4000	6000	8000
1								
2								
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Technician / MA: _____

Audiometer Last Calibration Date: _____

RESULTS

- NORMAL HEARING
 - PROGRAM ADMINISTRATOR FOLLOW UP AND AUDIOLOGIST CONSULTATION RECOMMENDED.
- | | | |
|--|--|--------------|
| <u>LEFT EAR</u> | <u>RIGHT EAR</u> | |
| <input type="checkbox"/> Normal | <input type="checkbox"/> Normal | (≤ 25 dB) |
| <input type="checkbox"/> Mild loss | <input type="checkbox"/> Mild loss | (26 - 40 dB) |
| <input type="checkbox"/> Moderate loss | <input type="checkbox"/> Moderate loss | (41 - 70 dB) |
| <input type="checkbox"/> Severe loss | <input type="checkbox"/> Severe loss | (71 - 90 dB) |
| <input type="checkbox"/> Profound loss | <input type="checkbox"/> Profound loss | (> 90 dB) |

RECOMMENDATIONS

- None
- Use hearing protection in noisy areas above 85 dB.
- Other:

Physician Signature: _____

This test may only be a part of your Hearing Conservation Program. Other environmental tests and administrative components apply.

