This visit is due to a workplace injury.

Employee Name: ____

Date of Injury: ____

Type of Injury: ____

Office Location: ____

Did this injury involve a needlestick? Yes _________ No _________
If Yes, please complete the following tests:

- HIV—repeat again at 6 weeks, 3 months, and 6 months
- Hep B
- Hep C—repeat at 2, 4, and 6 weeks
- AST/ALC

<u>Please bill to:</u>
CGPP Management
12140 Woodcrest Executive Dr, Suite 325
St. Louis, MO 63141
hr@pacesetter-health.com