URGENT MEDCARE
Get in. Get out. Get better.

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ _____ SS#: _____

Company Name: _____ Branch/Store #_____

Work Related: Date of Injury _____Body Part_____ New Injury ☐ Follow Up ☐

PHYSICAL EXAMINATION

☐ Pre-employment ☐ Annual ☐ DOT ☐ RTW ☐ Other _____

☐ Fit For Duty ☐ Respiratory Clearance

SUBSTANCE ABUSE TESTING

☐ DOT 5 Panel (send out to Lab) ☐ 5 Panel Instant ☐ Breath Alcohol Test (BAT)

☐ 5 Panel (send out to Lab) ☐ 10 Panel Instant ☐ DOT ☐ Non-DOT

☐ 10 Panel (send out to Lab) ☐ Urine Collection only ☐ Hair Collection (head only)

REASON FOR SUBSTANCE ABUSE TESTING

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-Accident

☐ Random ☐ Return to Work (RTW) ☐ Follow Up

ADDITIONAL SERVICES

☐ Audiometry ☐ TB Skin Test ☐ PFT (spirometry) ☐ EKG ☐ Lift Test 50 lbs. or 75 lbs.

☐ Vision Screening ☐ Agility Test ☐ X-Ray (1 View) ☐ COVID Other_____

BILLING

☐ **Employer Paid** ☐ **Insurance Carrier/TPA**

Employer Name _____HR/Safety Manager_____Phone_____

Address_____City/ST/Zip_____

Workers Comp Carrier Name_____ Claim #_____

Carrier Address_____City/ST/Zip_____

AUTHORIZER'S INFORMATION (REQUIRED)

Authorized by_____ Title _____ Date _____

Phone _____ Fax _____ Email _____

Verified by _____**(UMC Staff Member)** Date_____

Visit urgentmedcareonline for Daily Hours