URGENT MEDCARE

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SSN #: _____

Company Name: _____ Branch/Store #: _____

Work Related: Date of Injury _____ Body Part _____ ☐ New Injury ☐ Follow Up

Can Medications Be Dispensed? ☐ Yes ☐ OTC Only ☐ No

PHYSICAL EXAMINATION

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

☐ Fit For Duty ☐ Respiratory Clearance ☐ Silica/Asbestos ☐ OSHA Questionnaire

SUBSTANCE ABUSE TESTING

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

☐ 5 Panel (send out to our Lab Alere) ☐ 10 Panel Rapid ☐ DOT ☐ Non-DOT

☐ 10 Panel (send out to our Lab Alere) ☐ Urine Collection only (Client provided CCF) ☐ Hair Follicle Test

REASON FOR SUBSTANCE ABUSE TESTING

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-Accident

☐ Random ☐ Return to Duty (RTD) ☐ 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: _____ **(PIC Staff Member)** Date: _____