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: ______________________ **(Staff Member)** Date: ______________

12/2022