



★Due to the nature of services, only the patient is allowed in the testing/treatment area. Please alert your employee so that he/she can make arrangements for children or others that might otherwise accompany them to the clinic. ★

(Patient **MUST** present photo ID at time of service)

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ DOB: _____

Employer/Company Name: _____

Authorized by: _____ Date: _____
Signature

WORK INJURY TREATMENT AUTHORIZATION

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| Date of Injury: _____ | Injured Body Part: _____ |
| Date last worked: _____ | Special instructions: _____ |
| <u>Substance Abuse Testing</u> | |
| Specify: <input type="checkbox"/> DOT <input type="checkbox"/> NonDOT | |
| Drug Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Alcohol Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

PHYSICAL EXAM AUTHORIZATION

| | |
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| <p><u>Exam Type (check all that apply)</u></p> <p><input type="checkbox"/> DOT <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Annual</p> <p><input type="checkbox"/> Fitness for Duty <input type="checkbox"/> Other: _____</p> <p><u>Exam Components (check all that apply)</u></p> <p><input type="checkbox"/> Basic exam <input type="checkbox"/> Audiogram <input type="checkbox"/> PFT</p> <p><input type="checkbox"/> EKG <input type="checkbox"/> Lab: _____</p> <p><input type="checkbox"/> x-rays: _____</p> <p><input type="checkbox"/> Vision: specify <input type="checkbox"/> near <input type="checkbox"/> distance <input type="checkbox"/> depth <input type="checkbox"/> color</p> <p><input type="checkbox"/> Other: _____</p> | <p><input type="checkbox"/> Respiratory protection program</p> <p><input type="checkbox"/> Review OSHA questionnaire</p> <p><input type="checkbox"/> Respiratory physical exam</p> <p><input type="checkbox"/> Pulmonary function test (PFT)</p> <p><input type="checkbox"/> Respirator fit: <input type="checkbox"/> quant <input type="checkbox"/> qual</p> <p><input type="checkbox"/> Hearing conservation program</p> <p><input type="checkbox"/> Baseline <input type="checkbox"/> Annual <input type="checkbox"/> Exit</p> <p><input type="checkbox"/> Immunizations</p> <p><input type="checkbox"/> Tetanus/Diphtheria/Pertussis (Tdap)</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> MMR</p> <p><input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Tuberculosis (PPD) testing</p> |
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DRUG/ALCOHOL TEST AUTHORIZATION

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| <p><u>Department of Transportation (DOT) Testing</u></p> <p>Check all that apply:</p> <p><input type="checkbox"/> Drug Screen <input type="checkbox"/> Breath Alcohol Test</p> <p><input type="checkbox"/> Pre-Employment <input type="checkbox"/> Post-Accident</p> <p><input type="checkbox"/> Random <input type="checkbox"/> Reasonable Cause</p> <p><input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up</p> <p><input type="checkbox"/> Other: _____</p> <p>Special instructions: _____</p> <p>_____</p> | <p><u>Company mandated (nonDOT) Testing</u></p> <p>Check all that apply:</p> <p><input type="checkbox"/> <u>Urine Drug Screen</u> <input type="checkbox"/> Hair collection</p> <p><input type="checkbox"/> 5 Panel <input type="checkbox"/> Breath Alcohol Test</p> <p><input type="checkbox"/> 7 Panel <input type="checkbox"/> <u>Instant Test</u></p> <p><input type="checkbox"/> 9 Panel <input type="checkbox"/> 5 Panel</p> <p><input type="checkbox"/> 10 Panel <input type="checkbox"/> 10 Panel</p> <p><input type="checkbox"/> Other: _____</p> <p>Special instructions: _____</p> <p>_____</p> |
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