Employer Authorization for Examination &/or Treatment

Photo ID at Time of Service

Patient Name: ____________________ SS#: ____________________

Employer: ____________________ Date of Birth: ____________________

Company Address: ____________________ Date of Order: ____________________

Company Contact: ____________________ Company Ph#: ____________________

Billing:

____ Employee to Pay at Time of Service
____ Employer
____ Workers' Compensation
Insurance Company: ____________________
Policy #: ____________________
Phone #: ____________________

Work Related: ____ **Injury** ____ **Illness**

Date of Injury: ____________________

____ Rapid Urine Drug Test (not recommended for injuries)
____ Post Accident Drug Test ____ Dot ____ Non-DOT
____ Post Accident Breath Alcohol Test
____ Post Accident Hair Analysis
____ Other
____ **Light Duty is Available**

Return to Work Evaluation:

Job Title: ____________________
(Provide Job Description)
____ Occupational Injury
____ Non-Occupational Injury

Special Instructions: ____________________

Drug Testing Only:

____ **Random Testing** ____ **Reasonable Suspicion**
____ Urine Drug Test: ____ DOT ____ Non-DOT
____ Rapid Urine Drug Test
____ Breath Alcohol Test
____ Hair Analysis

Pre-Employment Services:

____ Urine Drug Test: ____ DOT ____ Non-DOT
____ Rapid Urine Drug Test
____ Breath Alcohol Test
____ Hair Analysis
____ Physicals: ____ DOT ____ DOT Re-Cert ____ Basic
____ Physical Performance Evaluation *(Provide Job Description)*
____ Respirator Fit Testing
____ Qualitative
____ Quantitative: Mask Type:
____ Pulmonary Function Test (PFT)
____ Audiogram: ____ DOT ____ OSHA Conversation
____ Blood Testing:
____ CBC ____ SMAC
____ Heavy Metal: (specify) ____________________
____ TB Skin Test
____ X-Ray: ____ Check ____ B-Read
____ Vision Testing:
____ Wall Chart ____ J-2 ____ ____ Color

Authorized By (Print): ____________________ Title: ____________________

Company: ____________________ Date: ____________________

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