# Authorization for Medical Services & Treatment

Patient Name ____________________

Employer ____________________

Address & City ____________________

Work Injury

Date of Injury __________ Affected body part(s) ____________________

**Billing for Workers Comp**

☐ Insurance Carrier __________ Policy # __________
Claim # __________ Effective Date __________

***Substance Abuse Testing**

- ☐ DOT Drug Screen
- ☐ NON-DOT Drug Screen
- ☐ Collection Only
- ☐ Instant Test
  - ☐ 5 panel ☐ 10 panel
- ☐ Breath Alcohol Test
- ☐ Other: __________

***Reason for Testing**

- ☐ Post Offer / New Hire
- ☐ Post accident / Post-injury
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Follow-up
- ☐ Return to Duty
- ☐ Per Company Request

**Additional Medical Services**

- ☐ Audiogram ☐ Hepatitis B Vaccine
- ☐ Lift Test
- ☐ PPD
  - ☐ One Step ☐ Two Step
- ☐ Bloodwork/titers __________
- ☐ Other: __________

****Physical Examination**

- ☐ Post Offer / New Hire
- ☐ Annual
- ☐ Exit
- ☐ Return to Work
- ☐ Fit for Duty
- ☐ DOT Post Offer or New Hire
- ☐ DOT Recertification
- ☐ School Bus

*****Special Examination**

- ☐ Respirator Physical
  - ☐ Spirometry ☐ Fit Testing
- ☐ Asbestos Physical
- ☐ HAZMAT Physical
- ☐ Medical Surveillance

* If having substance abuse testing please choose a reason for testing

** Scheduled Appointment is Preferred

*** These services may include specific OSHA requirements of both the Employer & Medical Provider. Please contact the clinic for instructions and scheduling info.

**Employee Health Services**

- ☐ Bill Employer
- ☐ Employee pays

**Special Instructions/Comments** ____________________

**Authorized by (print)** ____________________

**Phone** __________ **Date** __________

All patients are required to show photo identification before receiving treatment.
Please send this form with the employee, or fax it directly to the clinic (fax #'s are on the back)