OCCUPATIONAL HEALTH SERVICES

EMPLOYERS AUTHORIZATION FOR EXAMINATION OR TREATMENT

PATIENT NAME: _____ SSN#:_____

COMPANY NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____ DATE OF INJURY:_____

Appointment Date and Time: _____

PHYSICAL EXAMINATIONS

Reason ____ **Preplacement** ____ **Annual**

____ DOT Physical
____ Routine Physical
____ Complex Physical
____ Respirator Certification
____ Hazmat
____ Other_____

OTHER SERVICES

____ Agility ____ Lift Test
____ Audiogram ____ Titmus Vision
____ Chest X-Ray (1 or 2 Views)
____ EKG ____ PPD/TB
____ Immunization _____
(specify
____ PFT/Spirometry
____ Respirator Fit Test
____ Lab Draw _____
(specify test)

DRUG/ALCOHOL TESTING

____ Federal Regulated (DOT)
____ Non-Regulated (Non-DOT) 5 panel
____ Non-Regulated (Non-DOT) 10 panel
____ Urine Drug Screen Collection Only
____ Automatic UDS 5 panel
____ Automatic UDS 10 panel
____ Hair Collection 7 panel
____ Hair Collection only
____ Breath Alcohol (DOT)
____ Breath Alcohol (NON-DOT)

TEST TYPE

____ Preplacement
____ Random
____ Reasonable Suspicion
____ Post Accident
____ Periodic
____ Follow-up
____ Return to Duty

WORK RELATED INJURY

Injured body part_____
_____

Post-Accident Drug Screen Required
Yes____ No____

BILLING

____ Bill Company for Services
____ Bill Workers' Compensation Carrier

Carrier:_____
Address:_____
_____
Phone#:_____
Policy#:_____

Authorized by:_____ **Title:**_____

Phone:_____ **Date:**_____