AUTHORIZATION FOR TREATMENT FORM

COMPANY NAME: ______________________ DATE: ______________

PATIENT NAME: ______________________ DOB: ______________

ADDRESS: ______________________ PHONE: ______________

INJURY RELATED:

- ☐ Injury
  Date of Injury:
  ____
- ☐ Breath Alcohol Test
- ☐ Instant Drug Screen
- ☐ Non-Regulated Drug Screen
- ☐ Regulated Drug Screen

PHYSICAL EXAMS:

- ☐ Basic Physical
- ☐ DOT
- ☐ DOT Recertification
- ☐ Asbestos Exam
- ☐ Hazmat Exam
- ☐ Annual
- ☐ Baseline
- ☐ Exit
- ☐ Return to Work
- ☐ Fit for Duty
  (By appointment ONLY)
- ☐ Silica

DRUG SCREENING:

Please check type that apply

- ☐ ***Preplacement***
- ☐ ***Random***
- ☐ ***Reasonable Suspicion***
- ☐ ***Return to Duty***

- ☐ Instant Drug Screen
  ____________ panel
- ☐ Non-Regulated Drug Screen
- ☐ Regulated Drug Screen
- ☐ Hair Test
- ☐ Collection Only
- ☐ Other ____________

OTHER SERVICES:

- ☐ Respirator Physical
- ☐ Respirator Questionnaire Clearance
- ☐ Mask FIT Test
- ☐ TB Skin Test ☐ T-Spot test
- ☐ PFT (Pulmonary Function Test)
- ☐ Audiogram
- ☐ Vision Test
- ☐ X-Ray ☐ EKG
- ☐ Covid-19 test
  ☐ Instant ☐ PCR test
- ☐ Blood Draw
  *Specify:*____________
- ☐ Immunization
  *Type:*____________

SPECIAL INSTRUCTIONS: ____

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AUTHORIZED BY: ______________________ TITLE: ______________ PHONE: ______________