Authorization for Examination or Treatment

(patient must present authorization and photo ID at the time of service)

Patient Name: _____ Social Security No: _____

Employer: _____ Date of Birth: _____

Street Address: _____ Location: _____

Staffing Agency: _____

OCUPATIONAL HEALTH SERVICES

WORK RELATED

☐ Injury ☐ Illness

Date of Injury: _____

SUBSTANCE ABUSE TESTING

☐ **DOT** Drug Test ☐ **DOT** Breath Alcohol

☐ Collection Only ☐ Hair Collect

☐ Non-DOT Drug Screen ☐ Instant ☐ Lab Based

☐ 5 Panel ☐ 10 Panel ☐ 4 Panel ☐ 9 Panel

☐ Other: _____

REASON FOR TEST

☐ Pre-Placement ☐ Reasonable Suspicion

☐ Post Accident ☐ Random

☐ Follow Up

SPECIAL INSTRUCTIONS/COMMENTS

_____

_____

PHYSICAL EXAMINATION

☐ Pre-Placement ☐ Baseline ☐ Annual ☐ Exit

DOT EXAMS

☐ New Hire ☐ Recertification

SPECIAL EXAMINATIONS

☐ Asbestos ☐ Respiratory ☐ Hazmat

☐ Firefighter ☐ MCOLES ☐ Fit for Duty

☐ Audiogram ☐ Return to Work

☐ Other _____

Billing: ☐ Company Pay ☐ Employee Pay

Scan for Hours & Locations

Authorized by: _____ Title: _____

Please print

Phone: _____ Date: _____

(Copies of this form are available at www.occmedconnect.com)