OCCUPATIONAL MEDICINE
AUTHORIZATION FOR SERVICES

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PATIENT INFORMATION

Patient Name_____ Date of Birth_____

EMPLOYER/ORGANIZATION INFORMATION

Employer / Organization Authorizing Visit _____

Authorizing Contact Name _____ Authorizing Contact Phone_____

Authorizing Contact Email _____

PHYSICALS

- ☐ DOT Physical
  - ☐ Initial
  - ☐ Recertification
- ☐ General Work Physical
- ☐ Fit-for-Duty Physical
- ☐ Other: _____

DRUG/ALCOHOL SCREENS

☐ Pre-Employment ☐ Random ☐ Post Accident ☐ Other: _____

- ☐ DOT Drug Screen
- ☐ Hair Drug Screen
- ☐ Non-DOT Drug Screen
- ☐ Collection Only
- ☐ Rapid Drug Screen
- ☐ DOT Breath Alcohol
- ☐ Urine Alcohol (Ethyl) 24-48 H
- ☐ Non-DOT Breath Alcohol
- ☐ Urine Alcohol (ETG) 3-4 Days
- ☐ Other: _____

OTHER SERVICES

- ☐ Audio
- ☐ EKG
- ☐ Pulmonary Function Test
- ☐ Respirator Fit Test
- ☐ Other: _____

LABS

- ☐ Executive Panel
- ☐ QuantiFERON Gold TB
- ☐ Hep A Titer
- ☐ Hep B Titer
- ☐ Other_____

VACCINATIONS

- ☐ PPD (TB Test)
- ☐ Tdap
- ☐ Hep A Vaccine
- ☐ Hep B Vaccine
- ☐ Flu Vaccine
- ☐ Other: _____

WORKERS' COMP

☐Initial Visit ☐ Follow-Up Visit WC Insurance_____

WC Ins Adjuster Phone_____ Case/ Claim ID _____

WC Ins Email _____

ADDITIONAL INFORMATION OR COMMENTS

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Employer Authorized Representative Signature_____ Date_____