(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Today's Date: _____

Patient Name: _____ Date of Birth: _____

Employer: _____

Work Related
□ Injury □ Illness
Date of Injury _____

Employment Physical Examination
□ Pre-placement □ Baseline □ Annual □ Exit □ Return to Work

DOT Physical Examination
□ Pre-placement □ Recertification

Substance Abuse Testing (check all that apply)
□ Regulated drug screen
□ Breath alcohol
□ Collection only
□ Hair collect
□ Urine Collection Only
□ Non-regulated drug screen
□ Rapid drug screen
□ Other_____

Type of Substance Abuse Testing
□ Pre-placement □ Reasonable cause
□ Post-accident □ Random □ Follow-up

Billing: (check if applicable)
□ Employee to pay charges

Special instructions/comments:

_____

_____

Authorized by: _____ Title _____
Print Here
Phone: _____ Date_____