(Patient must present photo ID at time of service)

Authorization for Examination or Treatment

Patient Name: ______________________ Social Security Number: ______________________

Employer: ______________________ Date of Birth: ______________________

Work Related

Injury Illness

Substance Abuse Testing (select all that apply)

Regulated Drug Screen Breath Alcohol

10 Panel Rapid Non-Regulated

Other ______________________

Type of Testing

Pre-placement Reasonable Cause

Post-accident Random

Follow-up Observed

Physical Examination

Pre-placement Baseline Annual

Exit Respirator Hazmat Asbestos

DOT Physical Examination

Pre-placement Recertification

Other Services

Pulmonary Function Test OSHA Questionnaire

Medical Surveillance Respirator Fit Test

L2 Form HPE Lift Test

Audio Other ______________________

Special Instructions/Comments:

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Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the clinic.

Authorized by: ______________________ Title: ______________________

Phone: ______________________ Date of Authorization: ______________________

Date of Injury: ______________________ Valid Through: ______________________

Copies of this form are available at ***www.carexpressurgentcare.com***