OCCUPATIONAL AUTHORIZATION

Patient Name: ______________________ DOB:___/___/____ Date of Service: ___/___/____

Company Information:

Name: ______________________ DER Name: ______________________

Address: ______________________ Fax #: ______________________

City, ST. Zip: ______________________ Phone #: ______________________

Email: ______________________

Authorized By: ______________________

WORK RELATED INJURY

- ☐ Workers' compensation evaluation/treatment
- ☐ Labs Only: ______________________
- ☐ X-Ray Only: ______________________
- ☐ Post-accident drug screen
- ☐ Rapid In-House ☐ 5 Panel ☐ 10 Panel
- ☐ DOT drug screen collection/CCF required
- ☐ Non-DOT drug screen collection/CCF required

PHYSICALS

DOT	Non - DOT
☐ Pre-Employment	☐ Pre-Employment
☐ Recertification	☐ Annual Physical
☐ Follow-up	☐ Workplace Wellness
☐ Other: ______________	☐ Other: ______________

DRUG & ALCOHOL SCREENING

DOT		Non-DOT	
Drug	**Alcohol**	**Drug**	**Alcohol**
☐ Pre-Employment	☐ Follow-up	☐ Pre-Employment	☐ Follow-up
☐ Post Accident	☐ Pre-Employment	☐ Post Accident	☐ Pre-Employment
☐ Random	☐ Random	☐ Random	☐ Random
☐ Reasonable Suspicion	☐ Reasonable Suspicion	☐ Reasonable Suspicion	☐ Reasonable Suspicion
☐ Other: __________	☐ Return to Work	☐ Rapid In-House (Non-CCF)	☐ Return to work
	☐ Post Accident	☐ 5 Panel	☐ Post Accident
	☐ Saliva Test	☐ 10 Panel	☐ Saliva Test
	☐ Breath Test	☐ Other __________	☐ Breath Test
	☐ Other: _______		☐ Other: _______

OTHER SERVICES

- ☐ Audiogram
- ☐ Hepatitis B Vaccine
- ☐ Physical Capacity Profile (PCP)
- ☐ Spirometry
- ☐ Tetanus Vaccine
- ☐ Other: ______________________
- ☐ Special Instructions: ____

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