AUTHORIZATION FOR TREATMENT

(Must Present Photo ID at Time of Service)

Patient Name: ______________________________________ Date of Birth: ____________________________

Company: ____ Date of Order: ____________________

Company Address: ____ Company Phone: ___________________

Company Contact: ____ Title: ____________________________

Signature: ____ Date: ____________________________

Billing

☐ Employee to Pay at Time of Service

☐ Employer Responsible

Visit Reason

☐ Pre- Employment

☐ Annual

☐ Random

☐ Reasonable Suspicion

Exam:

☐ Non-DOT Exam

☐ DOT Exam

☐ Return to Work

☐ Respirator Clearance

☐ Other_____________

Drug Screens:

☐ Rapid Panel

☐ 10 Panel Send Out

☐ eScreen/ePassport

Acct#___________

☐ Collection Only

☐ Saliva Alcohol (Gunbarrel)

☐ Breath Alcohol (Market)

☐ Other____________

OTHER OCCUPATIONAL HEALTH SERVICES

☐Audio Booth (Market) ☐OSHA Audiogram(Ooltewah/Gunbarrel)

☐ Vision (circle) Ishihara Color/Peripheral/Snellen) ☐ EKG

☐ Respirator Fit Test ☐ PPD (TB skin test)

☐ Chest X-ray ☐ Lumbar Spine X-Ray

IMMUNIZATIONS

☐ Hepatitis A ☐ Hepatitis B ☐ MMR ☐ TDAP ☐ Flu Shot

LABS

☐ Varicella Titer ☐ MMR Titer ☐ Hep A Titer ☐ Hep B Titer ☐ QuantiFERON ☐Other ___________