Authorization for Examination or Treatment

Pivot Location: ___________________________

(Patient Must Present Photo ID at Time of Service)

Company Name: ____ **Today's Date**: _____________

Company Contact: ____ **Phone #**: ________________

Employee Name: ____ **DOB:** ____________________

Please check all that apply:

☐ **Work Injury/Workers Compensation**

Date of Injury: ______________________ Injury Description: ________________________________

Insurance Carrier: ______________________________ Claim #: _______________________________

Physical Examination

☐ Pre-placement ☐ DOT ☐ Periodic/Annual ☐ Exit ☐ Return to Work ☐ Fitness for Duty
☐ Respirator Clearance ☐ Respirator Questionnaire Review Only ☐ Hazmat (Include details below)
☐ Other: ______________________ Physical Instructions: ____

Substance Abuse Testing

☐ DOT ☐ 5 Panel ☐ 10 Panel ☐ Rapid 5 Panel ☐ Rapid 10 panel
DOT Testing Authority: ______FMCSA ______FAA ______FRA ______FTA ______PHMSA ______USCG
☐ Breath Alcohol ☐ Alcohol Saliva ☐ Other: ____
☐ Collection only—Lab Name: ________________________________ Chain of Custody: ☐ Yes ☐ No

Reason for Substance Abuse Testing

☐ Pre-placement ☐ Post-accident ☐ Random ☐ Reasonable Cause ☐ Follow Up ☐ Return-to-Work

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG ☐ Chest x-ray
☐ Vaccinations: ________________________ ☐ Blood Work: ________________________
☐ Other: ____

Special Instructions/Comments: ____

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Authorized By: __________________________________ **Signature:** _________________________________

For individual office hours and locations visit: **www.PivotOccHealth.com**