



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: _____

Authorized By: _____ **Signature:** _____