

## MEDICAL AUTHORIZATION

**Patient's Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Employer Name:** \_\_\_\_\_ **Acct #** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Authorized By:** \_\_\_\_\_ **Authorization Expires:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print Name)

### WORK-RELATED INJURY

- Work injury treatment       Consult to determine compensability      Body part: \_\_\_\_\_  
(Evaluation for cause of injury)

### EVALUATIONS / EXAMINATIONS

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> Pre-Placement Exam / Post-Offer Exam<br/>Job Title Optional _____</li> <li><input type="checkbox"/> Annual / Periodic Exam</li> <li><input type="checkbox"/> Firefighter New</li> <li><input type="checkbox"/> Firefighter Annual <i>(by appointment only - call clinic)</i></li> <li><input type="checkbox"/> Respirator Clearance Exam</li> <li><input type="checkbox"/> Respirator Fit Testing (no exam)</li> <li><input type="checkbox"/> Silica Clearance Examination <i>(by appointment only - call clinic)</i></li> <li><input type="checkbox"/> Asbestos Clearance Examination <i>(by appointment only - call clinic)</i><br/>____ Chest X-ray (B-Read)    ____ No Chest X-ray</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Fitness for Duty Evaluation <i>(return to work)</i></li> <li><input type="checkbox"/> School Bus Driver                             <ul style="list-style-type: none"> <li><input type="checkbox"/> Annual</li> <li><input type="checkbox"/> New Hire</li> </ul> </li> <li><input type="checkbox"/> DOT Exam                             <ul style="list-style-type: none"> <li><input type="checkbox"/> New Certification</li> <li><input type="checkbox"/> Recertification</li> </ul> </li> <li><input type="checkbox"/> Other: _____<br/><i>(Please complete if item is not listed)</i></li> </ul> |
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### DRUG & ALCOHOL SCREENING

#### NON-NIDA\* / NON-DEPARTMENT OF TRANSPORTATION

- | Drug                                          | Alcohol (EBT)                                 |
|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Pre-Employment       | <input type="checkbox"/> Pre-Employment       |
| <input type="checkbox"/> Random               | <input type="checkbox"/> Random               |
| <input type="checkbox"/> Follow-up            | <input type="checkbox"/> Follow-up            |
| <input type="checkbox"/> Reasonable Suspicion | <input type="checkbox"/> Reasonable Suspicion |
| <input type="checkbox"/> Return to Duty       | <input type="checkbox"/> Return to Duty       |
| <input type="checkbox"/> Post-Accident        | <input type="checkbox"/> Post-Accident        |
| <input type="checkbox"/> Hair Follicle Drug   | <input type="checkbox"/> Other: _____         |
| <input type="checkbox"/> Rapid                |                                               |
| <input type="checkbox"/> Other: _____         |                                               |

#### NIDA\* / DEPARTMENT OF TRANSPORTATION

- | Drug                                          | Alcohol (EBT)                                 |
|-----------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Pre-Employment       | <input type="checkbox"/> Random               |
| <input type="checkbox"/> Random               | <input type="checkbox"/> Follow-up            |
| <input type="checkbox"/> Follow-up            | <input type="checkbox"/> Reasonable Suspicion |
| <input type="checkbox"/> Reasonable Suspicion | <input type="checkbox"/> Return to Duty       |
| <input type="checkbox"/> Return to Duty       | <input type="checkbox"/> Post-Accident        |
| <input type="checkbox"/> Post-Accident        |                                               |

### OTHER SERVICES

- |                                                      |                                              |
|------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Audiogram                   | <input type="checkbox"/> Quantiferon Gold    |
| <input type="checkbox"/> Tuberculosis (TB) Skin Test | <input type="checkbox"/> Hepatitis B Vaccine |
| <input type="checkbox"/> Other: _____                |                                              |

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