OCCUPATIONAL MEDICINE AUTHORIZATION FORM

Company ______________________________ Patient Name ______________________________
Contact ______________________________ Date of Service ______________________________
Contact # ______________________________ Reason for Service ______________________________

PLEASE SELECT ALL SERVICES YOU WOULD LIKE PERFORMED

EXAM

☐ Pre-Employment Exam ☐ HOIST Operator
☐ DOT Medical Cert Exam ☐ ALPOST Physical
☐ Return to Duty Exam
☐ OSHA Respiratory Medical Evaluation

WORK RELATED INJURY

Date of Injury ______________________________
Claim# ______________________________
☐ Initial Evaluation & Treatment
☐ Revaluation

I understand that I am requesting treatment for the above-mentioned individual for a work-related incident. If I do not provide a claim number within 7 days of the treatment date, I understand that all costs will be the responsibility of the company to pay.

Signature: ______________________________

BILL TO:

☐ Company Above ______________________
☐ Workers' Comp ______________________
☐ Third Party ______________________

DRUG SCREENING

NON-DOT SCREENS
☐ Instant 12-Panel
☐ Collection Only (company form)
☐ Non-Federal (UCNW form)

DOT SCREENS
☐ DOT/FMCSA (UCNW form)
☐ Collection Only (company form)
☐ Send non-negative for confirmation

ALERE SOUTHERN COMPANY
☐ Contractor Instant
☐ Contractor Send-Out

ALCOHOL TESTING
☐ Blood Alcohol
☐ Breath Alcohol ☐ DOT ☐ Non

HAIR TESTING
☐ Hair Collection & Screen

SCREENING

☐ Visual Screen
☐ Audiometer Screen
☐ EKG

TB SCREENING
☐ TB Skin Test (PPD)
☐ QuantiFERON Gold PPD
☐ CXR TB Screen

MISCELLANEOUS SERVICES

Vaccines ☐ Hep B ☐ Flu ☐ Tdap ☐ MMR ☐ Varicella ☐ Other ________________
Titer ☐ Hep B ☐ MMR ☐ Varicella ☐ Other ________________

☐ Lead-Occupational
☐ ZPP
☐ Spirometry
☐ CXR w/ B-Reader

☐ OTHER SERVICE ____

Special Notes or Instructions ____

This form will serve as your authorization to perform the selected procedures and tests on your employee. Please sign and date below. Please contact us if you have additional requests not shown on this list or if you have further questions or instructions. It is our pleasure to serve your occupational medicine needs.

______________________________ ______________________________ ____________________
(Signature of Company Representative) *(Printed Name)* *(Date)*