*All services require photo ID to be provided at time of service

PATIENTS FIRST
Get in. Get out. Get better.

# AUTHORIZATION FOR EXAMINATION OR MEDICAL TREATMENT

Patient Name: _____ _____ SS#: _____

Company Name: _____ Branch/Store #_____

Work Related: Date of Injury _____Body Part_____ New Injury ☐ Follow Up ☐

## PHYSICAL EXAMINATION

**Donor will bring in Physical form Yes___ Use our Form ___**

☐ Pre-employment ☐ Annual ☐ DOT ☐ RTW ☐ Fit for Duty

☐ OSHA Respiratory Physical (PFT & Exam) ☐ OSHA Respiratory Clearance (PFT & Questionnaire only)

## SUBSTANCE ABUSE TESTING – Florida Drug Free Workplace

☐ DOT 5 Panel (send out to Lab) NIDA ☐ 5 Panel HRS ☐ DOT Breath Alcohol Test

☐ 5 Panel (send out to Lab) ☐ 8 Panel HRS ☐ Non-DOT Breath Alcohol Test

☐ 10 Panel (send out to Lab) ☐ 10 Panel HRS ☐ Urine Collection only/ Donor brings COC

## REASON FOR SUBSTANCE ABUSE TESTING

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-Accident

☐ Random ☐ Return to Work (RTW) ☐ Follow Up

## ADDITIONAL SERVICES

☐ Audiometry ☐ TB Skin Test ☐ PFT ☐ EKG ☐ Lift Test 50 lbs or 75 lbs

☐ Vision Screening ☐ Agility Test ☐ X-Ray (1 View) ☐ COVID Other_____

## BILLING

☐ **Employer Paid** ☐ **Insurance Carrier/TPA**

Employer Name _____HR/Safety Manager_____Phone_____

Address_____City/ST/Zip_____

Workers Comp Carrier Name_____ Claim #_____

Carrier Address_____ City/ST/Zip_____ Phone_____

**AUTHORIZER'S INFORMATION (REQUIRED)**

Authorized by_____ Title _____ Date _____

Phone _____ Fax _____ Email _____

**Verified by _____(PF Staff Member) Date:_____Time:_____**