



AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SSN #: _____

Company Name: _____ Branch/Store #: _____

Work Related: Date of Injury _____ Body Part _____ New Injury Follow Up

Can Medications Be Dispensed? Yes OTC Only No

PHYSICAL EXAMINATION

Pre-employment Annual DOT RTW Other: _____
Fit For Duty Respiratory Clearance Silica/Asbestos OSHA Questionnaire

SUBSTANCE ABUSE TESTING

DOT 5 Panel (send out to Lab) 5 Panel Rapid Breath Alcohol Test (BAT)
5 Panel (send out to our Lab Alere) 10 Panel Rapid DOT Non-DOT
10 Panel (send out to our Lab Alere) Urine Collection only (Client provided CCF) Hair Follicle Test

REASON FOR SUBSTANCE ABUSE TESTING

Pre-employment Reasonable Suspicion Post-Accident
Random Return to Duty (RTD) Follow Up

ADDITIONAL SERVICES

Audiometry TB Skin Test PFT (Spirometry) 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: _____

AUTHORIZER'S INFORMATION (REQUIRED)

Authorized by: _____ Title: _____ Date: _____

Phone: _____ Fax: _____ Email: _____

Verified by: _____ (PIC Staff Member) Date: _____