



AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SS#: _____

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)

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 _____

If any additional services are required, please add. _____

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 _____

AUTHORIZED CONTACT INFORMATION (REQUIRED)

Authorized by _____ Title _____ Date _____

Phone _____ Fax _____ Email _____

Verified by _____ (PF Staff Member) Date _____