LOCAL MD URGENT CARE

MEDICAL AUTHORIZATION

Patient's Name: _____ Date: _____

Employer Name: _____ Acct #: _____ Phone: _____

Authorized By: _____ Authorization Expires: _____
(Print Name)

WORK-RELATED INJURY

☐ Work Injury Treatment ☐ Consult to Determine Compensability
(Evaluation for cause of injury)
Body Part: _____

EVALUATIONS / EXAMINATIONS

☐ Pre-Placement Exam / Post-Offer Exam
Job Title: _____
(Optional)
Lift Test
Weight: _____

☐ School Bus Driver
- ☐ Annual
- ☐ New Hire

☐ DOT Exam
- ☐ New Certification
- ☐ Recertification

DRUG & ALCOHOL TESTING

NON-DOT

Drug	Alcohol
☐ Pre-Employment	☐ Pre-Employment
☐ Random	☐ Random
☐ Follow-Up	☐ Follow-Up
☐ Reasonable Suspicion	☐ Reasonable Suspicion
☐ Return to Duty	☐ Return to Duty
☐ Post-Accident	☐ Post-Accident
☐ Hair Follicle Drug	☐ Other: _____
☐ Rapid	
☐ Other: _____	

DOT-DEPARTMENT OF TRANSPORTATION

Drug	Alcohol
☐ Pre-Employment	☐ Pre-Employment
☐ Random	☐ Random
☐ Follow-Up	☐ Follow-Up
☐ Reasonable Suspicion	☐ Reasonable Suspicion
☐ Return to Duty	☐ Return to Duty
☐ Post-Accident	☐ Post-Accident
☐ Other: _____	

*National Institute on Drug Abuse

OTHER SERVICES

☐ Fit Testing ☐ Quantiferon Gold ☐ Tuberculosis (TB) Skin Test

☐ Other: _____