Authorization for Examination or Treatment

Patient First
www.patientfirst.com

Please check off services needed for your employee's visit.

Patient Information:

Company Name:	Date of Birth:	I.C. #:
Patient Name:	SS#:	

Work Related:

❑ Injury ❑ Illness Date of Injury _____

Physical Examination:

DOT:
❑ Pre-employment ❑ Recertification

NON-DOT:
❑ Pre-employment

Substance Abuse Testing:

Urine Drug Screens:

❑ DOT (5-panel)

❑ Non-DOT (10-panel)

❑ Instant Drug Screen (5-panel)

Alcohol Screens:

❑ Breath test (EBT)

❑ Blood test

Special Procedures:

❑ PPD Placement

❑ Chest X-ray

❑ Hepatitis B

❑ Flu vaccination

❑ Other _____

Special Instruction / Comments

Authorization:

Phone:	Date:
Printed Name:	Signature:

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