



Occupational Medicine

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Authorization for Treatment or Exam

Client Information	<input type="checkbox"/> New Account	Date _____
Company Name:	Designated Employee Representative (DER):	
DER Phone Number:	Fax/Email:	
Billing Invoice To:	Billing Address	

Authorized Tests or Examinations

<p>Physical Examinations:</p> <input type="checkbox"/> Pre-Placement Exam <input type="checkbox"/> Company/ TPA Exams <input type="checkbox"/> DOT Exam <input type="checkbox"/> Asbestos Exam <input type="checkbox"/> HAZMAT Exam <input type="checkbox"/> Silica <input type="checkbox"/> MCOLES <input type="checkbox"/> Fit For Duty <input type="checkbox"/> Return To Work <p>Audio:</p> <input type="checkbox"/> Forced Whisper Test <input type="checkbox"/> Audiogram <p>Respiratory:</p> <input type="checkbox"/> OSHA Respiratory Questionnaire <input type="checkbox"/> Respiratory Fit Test <input type="checkbox"/> Spirometry <input type="checkbox"/> Peak Flow Meter <p>Vision:</p> <input type="checkbox"/> Snellen (Distance) <input type="checkbox"/> Titmus (Distance/Near/Peripheral/Color) <input type="checkbox"/> Ishihara (Color) <input type="checkbox"/> Intermediate Vision <input type="checkbox"/> Depth Perception <input type="checkbox"/> Hardy Rand Ritter	<p>Lift Test:</p> <input type="checkbox"/> In-office 30lbs <input type="checkbox"/> In-office 50lbs <input type="checkbox"/> Physical therapy lift <p>Labs:</p> <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> Lipid Panel <input type="checkbox"/> THS <input type="checkbox"/> Heavy Metals <input type="checkbox"/> Urine with Microscopy <input type="checkbox"/> Other _____ <p>Substance Use Testing:</p> <input type="checkbox"/> Breath Alcohol Testing <input type="checkbox"/> Saliva Drug Screen <input type="checkbox"/> Hair Drug Screen <input type="checkbox"/> Urine Drug Screen <p>Radiology:</p> <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> B-Read <input type="checkbox"/> Lumbar Spine X-Ray <p>EKG:</p> <input type="checkbox"/> 12- Lead EKG	<p>Titers/Vaccines:</p> <input type="checkbox"/> Hep B <input type="checkbox"/> MMR <input type="checkbox"/> Varicella <input type="checkbox"/> Quntiferon Gold <input type="checkbox"/> TB Skin <input type="checkbox"/> Influenza <input type="checkbox"/> TDaP (PPD) <input type="checkbox"/> Other _____ <p>Special Instructions: _____ _____ _____</p> <p><input type="checkbox"/> I authorize all services requested by <i>(insert your company name)</i> _____, in accordance with the current fee schedule.</p> <p>Authorized Signature: _____</p> <p><small>*Employer accepts financial responsibility for all authorized services. *Please bring a Photo ID</small></p>
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Please email Complete Authorization to: BellOccMed@lifepointhealth.net **(Bell)**

OccMed@mghs.org **(Escanaba)**