



Occupational Medicine

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Authorization for Treatment or Exam

Client Information		<input type="checkbox"/> Employee Specific	Date _____
Company Name:		Designated Employee Representative (DER):	
DER Phone Number:		Fax/Email:	
Employee Information:			
Name:		Date of Birth:	Phone #:
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"/> Respirator Medical Clearance Exams <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>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"/> Quniferon Gold <input type="checkbox"/> TB Skin <input type="checkbox"/> Influenza <input type="checkbox"/> TDaP (PPD) <input type="checkbox"/> Other _____ <p>Reason For Drug Alcohol Test:</p> <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Post Accident <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Random <input type="checkbox"/> Follow Up <input type="checkbox"/> Return to duty	<p>DOT Drug/ Breath Alcohol Screening (Check All That Apply):</p> <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Urine <input type="checkbox"/> Collection Only (Employer will send donor with a chain of custody) <p>Authority:</p> <input type="checkbox"/> FMCSA <input type="checkbox"/> FAA <input type="checkbox"/> FRA <input type="checkbox"/> FTA <input type="checkbox"/> PHMSA <input type="checkbox"/> USCG <p>NON DOT Drug/Breath Alcohol Screens:</p> <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Urine <input type="checkbox"/> Hair <input type="checkbox"/> Saliva <input type="checkbox"/> Collection Only (Employer will send donor with a chain of custody) <p>NON DOT Rapid Drug Screen UPHS MRO:</p> <input type="checkbox"/> 5 Panel <input type="checkbox"/> 6 Panel <input type="checkbox"/> 9 Panel <input type="checkbox"/> 10 Panel <p>NON DOT (Lab Based) UPHS MRO:</p> <input type="checkbox"/> 5 Panel <input type="checkbox"/> 6 Panel <input type="checkbox"/> 9 Panel <input type="checkbox"/> 10 Panel	
Authorized Signature: _____		Special Instructions: _____	
*Employer accepts financial responsibility for all authorized services. *Please bring a Photo ID		_____	

Please email Complete Authorization to: BellOccMed@lifepointhealth.net (Bell)

OccMed@mghs.org (Escanaba)