Occupational Medicine

☐ 710 S. Lincoln Road, Suite 800 • Escanaba, MI 49829 • (906) 786-0440
☐ 901 Lakeshore Drive, Suite 106 • Ishpeming, MI 49849 • (906) 485-2267
☐ 1414 W. Fair Avenue, Suite 35 • Marquette, MI 49855 • (906) 449-1140

Authorization for Treatment or Exam

Client Information ☐ New Account Date _____

Company Name:	Designated Employee Representative (DER):
DER Phone Number:	Fax/Email:
Billing Invoice To:	Billing Address

Authorized Tests or Examinations

Physical Examinations:
☐ Pre-Placement Exam
☐ Company/ TPA Exams
☐ DOT Exam
☐ Asbestos Exam
☐ HAZMAT Exam
☐ Silica
☐ MCOLES
☐ Fit For Duty
☐Return To Work

Audio:
☐ Forced Whisper Test
☐ Audiogram

Respiratory:
☐ OSHA Respiratory Questionnaire
☐ Respiratory Fit Test
☐ Spirometry
☐ Peak Flow Meter

Vision:
☐ Snellen (Distance)
☐ Titmus (Distance/Near/Peripheral/Color)
☐ Ishihara (Color)
☐ Intermediate Vision
☐ Depth Perception
☐ Hardy Rand Ritter

Lift Test:
☐ In-office 30lbs
☐ In-office 50lbs
☐ Physical therapy lift

Labs:
☐ CBC
☐ CMP
☐ Lipid Panel
☐ THS
☐ Heavy Metals
☐ Urine with Microscopy
☐ Other _____

Substance Use Testing:
☐ Breath Alcohol Testing
☐ Saliva Drug Screen
☐ Hair Drug Screen
☐ Urine Drug Screen

Radiology:
☐ Chest X-Ray
☐ B-Read
☐ Lumbar Spine X-Ray

EKG:
☐ 12- Lead EKG

Titers/Vaccines:
☐ Hep B
☐ MMR
☐ Varicella
☐ Quntiferon Gold
☐ TB Skin
☐ Influenza
☐ TDaP (PPD)
☐ Other _____

Special Instructions: _____
_____
_____

☐ **I authorize all services requested by *(insert your company name)***
_____**, in accordance with the current fee schedule.**

Authorized Signature:

_____
*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 **(Marquette/Escanaba)**