CAPITOL ULTRASONICS
A PREMIUM COMPANY

CORE COMPREHENSIVE OCCUPATIONAL RESOURCES

Medical Authorization Form

Patient Name: _____ Patient ID/SSN: _____ - ____ - _____

Job / P.O.#: _____ Order Date: _____

Scheduler Name: _____ Scheduler # : _____

Authorizing Signature: _____

REASON FOR THIS VISIT ***Please check ALL services requested***

☐ Pre-Employment / Annual ☐ Post Accident ☐ Return to Duty

☐ Random ☐ Reasonable Cause ☐ Follow Up

Physical Examination

☐ Return to Work ☐ Non-DOT ☐ DOT

Ancillary Test

☐ Audiometric Test ☐ Pulmonary Function Test ☐ Respirator Fit Test

Respirator Mask

☐ 3M 6000 HF ☐ 3M 7800 FF ☐ MSA Ultraview (Honeywell Med ONLY)

Substance Abuse Testing

☐ DISA Breath Alcohol Test ☐ DISA Instant 10 Panel

☐ DISA Collect Only DOT ☐ DISA Collect only Non-DOT ☐ DISA Hair collection

Injury Treatment

☐ New Injury ☐ Follow Up Visit

Other Services

_____

_____