

Medical Authorization Form

Patient Name: _____	Patient ID/SSN: _____ - _____ - _____
Company: _____	Job / P.O.#: _____
Scheduler Name: _____	Scheduler #: _____

REASON FOR THIS VISIT *Please check ALL services requested*

<input type="checkbox"/> Pre-Placement	<input type="checkbox"/> Random	<input type="checkbox"/> Reasonable Cause	<input type="checkbox"/> Recheck
<input type="checkbox"/> Post Accident	<input type="checkbox"/> Company Specific Protocol: _____		

Physical Examination

<input type="checkbox"/> Pre-placement	<input type="checkbox"/> Lead	<input type="checkbox"/> Benzene
<input type="checkbox"/> DOT	<input type="checkbox"/> Vinyl Chloride	<input type="checkbox"/> Operator
<input type="checkbox"/> HAZWOPER	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Other: _____

Ancillary Test

<input type="checkbox"/> Audiogram	<input type="checkbox"/> EKG
<input type="checkbox"/> Respirator Clearance	<input type="checkbox"/> Pulmonary Function (PFT)

Qualitative Fit Testing

<input type="checkbox"/> North 7660 FF	<input type="checkbox"/> North 7700 ½ Face	<input type="checkbox"/> 3M 6000 ½ Face
<input type="checkbox"/> 3M FF 6800	<input type="checkbox"/> MSA Comfo Classic	<input type="checkbox"/> MSA Ultraview
<input type="checkbox"/> Scott AV 2000 FF	<input type="checkbox"/> Scott AV3000	<input type="checkbox"/> Other: _____

Substance Abuse Testing

<input type="checkbox"/> DOT ~~~~~ A ~~~~~	<input type="checkbox"/> Non DOT- Panel: _____	<input type="checkbox"/> Instant drug screen ~~~~~ A
<input type="checkbox"/> Breath Alcohol ~~~~~ A ~~~~~	<input type="checkbox"/> Saliva Alcohol ~~~~~	<input type="checkbox"/> Hair collection ~~~~~ A

If applicable, please write next to each service if it is DISA or NASAP testing

Injury Treatment

Laboratory Test

Chest X-Ray

<input type="checkbox"/> Workmen's Comp.	<input type="checkbox"/> Lead / ZPP (blood)	<input type="checkbox"/> 1 View
<input type="checkbox"/> Gen. Liability	<input type="checkbox"/> CBC / Industrial Chemistry	<input type="checkbox"/> 2 View <input type="checkbox"/> B reader

Injections

<input type="checkbox"/> Flu Vaccine	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tetanus Shot
<input type="checkbox"/> TB Skin Test	<input type="checkbox"/> Other: _____	

Comments/Notes

AUTHORIZED BY: _____ **Contact Phone:** _____