COMPREHENSIVE OCCUPATIONAL RESOURCES, LLC

Medical Authorization Form

Patient Name: ________________________ **Patient ID/SSN:** ______ - ____ - ________

Company: ___________________________ **Job / P.O. #:** ________________________________

Scheduler Name: _____________________ **Scheduler #:** _______________________________

REASON FOR THIS VISIT *Please check ALL services requested*

☐ Pre-Placement ☐ Random ☐ Reasonable Cause ☐ Recheck

☐ Post Accident ☐ Company Specific Protocol: __________________________

Physical Examination

☐ Pre-placement	☐ Lead	☐ Benzene
☐ DOT	☐ Vinyl Chloride	☐ Operator
☐ HAZWOPER	☐ Asbestos	☐ Other: _________________

Ancillary Test

☐ Audiogram	☐ Supplied AirĐÓ[¢¦^¸ ææ&@	☐ F€:00 AMÁÁÁÁÁÁÁÁFK€€ÁÚT
☐ Respirator Clearance	ÁÁÁÁÁÁÁÁÁÁÁÁÁÁÁV¦ææ ã *	
☐ EKG	☐ Ó¦^ææ@ã * ÁÓ[¢ÁV¦ææ ã *	
☐ Pulmonary Function (PFT)	*ÁÇÖ^^¦ÁÚæ\Á[}|^Á|^æ•^Á&@[•^ÁææÁã[^D*	

Qualitative Fit Testing

☐ North 7660 FF	☐ North 7700 ½ Face	☐ 3M 6000 ½ Face
☐ 3M FF 6800	☐ MSA Comfo Classic	☐ MSA Ultraview
☐ Scott AV 2000 FF	☐ Scott AV3000	☐ Other: _________________

Substance Abuse Testing

☐ DOT ______	☐ Non DOT- Panel: ______	☐ Instant drug screen ______
☐ Breath Alcohol ______	☐ Saliva Alcohol ______	☐ Hair collection ______

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

Injury Treatment	Laboratory Test	Chest X-Ray
☐ Workmen's Comp.	☐ Lead / ZPP (blood)	☐ 1 View
☐ Gen. Liability	☐ CBC / Industrial Chemistry	☐ 2 View ☐ B reader

Injections

☐ Flu Vaccine	☐ Hepatitis B	☐ Tetanus Shot
☐ TB Skin Test	☐ Other: ____	

Comments/Notes

AUTHORIZED BY:______________________________ **Contact Phone:** _________________________