AUTHORIZATION FOR MEDICAL SERVICES

Today's Date: _____ Employee Name:_____

Company Name: _____ Company Phone:_____

Company Address: _____ Authorized By:_____

Office Use only (telephone authorization received by): _____

Insurance Information: (Workers Compensation Only)

Insurance Carrier: _____ Policy number: _____

Date of Injury: _____ Protocol on file: Yes_____No _____

***If Drug Screen is needed with treatments, please write it under "SPECIAL INSTRUCTIONS" below.**

Tests:

☐ Covid-19 Rapid Test ☐ Covid-19 PCR test ☐ TB Skin Test

Physicals: (Occupational Medicine)

*Check the box for the services needing to be rendered. Protocol on file: Yes_____No _____

☐ Work Related Physical ☐ DOT/DMV Physical ☐ Other: 1. _____
2. _____
3._____

Drug Screening: (Occupational Medicine & Workers Compensation)

Reason for Drug Screen: ☐ Pre-Placement ☐ DOT/DMV ☐ Random ☐ Return to Duty ☐ Post-Accident
☐ Follow-Up ☐ Reasonable Suspicion

Type of Test: ☐ Non-NIDA, Standard 5 panel ☐ Non-NIDA, Special Panel (Please specify)___

☐ NIDA-5 PANEL SPLIT ☐ eCup, Panel_____ ☐ xCup, Panel _____

Processing Instructions for Staff:_____**Collect sample and send to:** _____

Special Instructions:

_____

_____

Patient instructions:
Photo ID required to complete drug screenings. Please be well hydrated in order to give urine sample.

Patients under 18 require parent or legal guardian consent.

After hours, visit the nearest emergency department.

4062 Flying C Rd.
Cameron Park, CA 95682
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F: