

Employer's Authorization for Examination or Treatment

Company Name: _____ Phone: (_____) _____ - _____

Patient: _____ SSN: _____

Date of Birth: ____ / ____ / ____ Address: _____

Date of Injury: ____ / ____ / ____ WORK-RELATED (check one) INJURY ILLNESS

Instructions: 1. Please mark the test(s) to be performed under the corresponding section.
2. Fax both pages to Approxie Health at 256.325.0240

| | |
|---|---|
| <p>INJURY / ILLNESS EVALUATIONS</p> <p><input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS</p> | <p>POST ACCIDENT SUBSTANCE ABUSE TESTING</p> <p><input type="checkbox"/> Breath Alcohol Test</p> <p><input type="checkbox"/> DOT Regulated Urine Drug Screen <i>(specimen may be collected at AFC or Quest)</i></p> <p><input type="checkbox"/> Non-DOT Non-regulated Urine Drug Screen</p> |
| <p>PRE-PLACEMENT EVALUATION</p> <p>Job Title: _____</p> <p><input type="checkbox"/> Basic Physical Exam <i>(Must forward copy of applicant's job description)</i></p> <p><input type="checkbox"/> DOT Physical</p> <p><input type="checkbox"/> DOT Regulated Urine Drug Screen <i>(specimen may be collected at AFC or Quest)</i></p> <p><input type="checkbox"/> Non-DOT Non-regulated Urine Drug Screen</p> | <p>DOT PHYSICAL</p> <p><input type="checkbox"/> Pre-placement <i>(Must forward copy of applicant's job description)</i></p> <p><input type="checkbox"/> Recertification <input type="checkbox"/> Breath Alcohol Test</p> <p><input type="checkbox"/> DOT Regulated Urine Drug Screen <i>(specimen may be collected at AFC or Quest)</i></p> <p><input type="checkbox"/> Non-DOT Non-regulated Urine Drug Screen</p> |
| <p>VACCINATIONS</p> <p><input type="checkbox"/> Hepatitis A Shot <i>(2 shots – 6 months apart)</i></p> <p><input type="checkbox"/> Hepatitis A Titre <i>(send Blood to Quest)</i></p> <p><input type="checkbox"/> Hepatitis B Shots <i>(Hepatitis B priced per shot. 3 shots required for complete testing)</i></p> <p><input type="checkbox"/> Hepatitis B Titre <i>(send Blood to Quest)</i></p> <p><input type="checkbox"/> Additional International Travel Vaccinations: _____</p> | |
| <p>SUBSTANCE ABUSE TESTING</p> <p><input type="checkbox"/> DOT Regulated <input type="checkbox"/> Non-regulated <input type="checkbox"/> Pre-placement <input type="checkbox"/> Reasonable Suspicion <input type="checkbox"/> Breath Alcohol Test</p> <p><input type="checkbox"/> Random <input type="checkbox"/> Periodic <input type="checkbox"/> Post –accident <input type="checkbox"/> Follow-up <input type="checkbox"/> Blood Alcohol Test</p> <p>Other Special Requests: _____</p> | |

Authorized By: _____ Date: _____

Title/Department: _____

Phone: (_____) _____ - _____ Email: _____