Coordinated Health

(Patient Must Present Photo ID at Time of Service)
(Testing will not be performed without this authorization)

Authorization for Examination or Treatment

Patient Name: _____ SS#: _____

Employer: _____ DOB: _____

Street Address: _____ Temp Staffing Agency: _____

Work Related

☐ Injury ☐ Illness

Date of Injury _____

Substance Abuse Testing (check all that applies)

☐ Drug Screen ☐ Breath alcohol ☐ Collection Only

☐ DOT Drug Screen ☐ Hair collection

Type of Substance Abuse Testing

☐ Pre-Employment ☐ Reasonable Suspicion

☐ Post-accident ☐ Random

☐ Follow-up

Special instructions/other testing:

_____

_____

_____

Billing (check if applicable)

☐ Employee to pay charges

☐ Employer to pay charges

☐ WC Insurance Carrier to pay charges

Physical Examination

☐ Basic Physical ☐ DOT Physical ☐ Asbestos Exam

☐ Fire Fighter Exam ☐ Return to Work

☐ Other _____

Additional Testing

☐ TB Test (1st Step) ☐ TB Test (2nd Step)

☐ Back Evaluation (lift test_____lbs.)

☐ Vaccinations _____

☐ Titers _____

☐ Lab Tests _____

☐ Spirometry (PFT) ☐ Respiratory Questionnaire

☐ Audiogram ☐ Respiratory Fit Test

☐ Vision _____

☐ Chest X-Ray (2-View)

☐ Fitness (performed in the Physical Therapy Dept.)

☐ Other _____

Authorized by: _____ Title: _____

Please print

Phone: (___) _____ Date: _____

CH now offers walk-in care services for non-work related illness and injury. We accept many insurance plans.
(Copies of this form are available at www.coordinatedhealth.com)