Treatment Authorization Form

Date: **Employee SSN (Last 4):**

Employee Name: **DOB:**

Company Name:

Company Phone #:

Questions to (Print Name): **Ph. #:**

Person Authorizing Treatment:

Ph: **Fx:**

Email:

The employer requesting service is responsible for payment in cases of denial or first aid determination.

Services Request

☐ **Group Treatment Authorization**

☐ **Single Treatment Authorization**

Check each requested medical service

Medical Exam Types	
Basic Medical Physical Exam	
DMV/DOT Medical Exam	
* Haz-Mat Physical Exam	
Fit for Duty Physical Exam	
Pre-Employment Physical Exam	
Travel Physical Exam/Consult	

* IMG must have company protocol file

Vaccines	
Tetanus (dT)	
Tdap Tetanus/Pertussis	
Flu Shot	
Hepatitis A	
Hepatitis B	
MMR	

Laboratory Testing	
Hepatitis B Titer	
MMR Titer	
Varicella Titer	
Complete Blood Count and Chemistry Panel (CBC with Chem)	
Lipids (Cholesterol/Triglycerides)	
Cholinesterase Baseline with PFT	
Cholinesterase Routine Draw	
Thyroid Panel	
Heavy Metals	
Lead	
Zinc Protoporphyrin (ZPP)	
PSA	

Drug & Alcohol Testing	
Drug Screening Non-DOT	
Drug Screening DOT	
Quick Test/Rapid Drug Screening	
Breath Alcohol Testing Non-DOT	
Breath Alcohol Testing DOT	

Reason for Testing	
Pre-employment	
Random	
Reasonable Suspicion	
Post-accident	
Return to Duty	
Follow Up	
Other	

Worker Compensation Injury Treatment	
Treatment of Industrial Injuries	

Workers' compensation requires full SS#

SS#:

Date of Injury:

Other Medical Components	
Health Screen Questionnaire Review	
Urinalysis (UA Dip Test)	
Urinalysis (UA Complete)	
Chest X-Ray 1 View	
Chest X-Ray 2 Views	
CXR with positive skin test	
Back X-Ray	
Back Flexibility	
Functional Capacity Test	
Respirator Questionnaire	
Pulmonary Function Testing (PFT)	
Resting Electrocardiogram (EKG)	
Cardiac Stress Test	
Alteration Fee	
Form Fee	
Audio Exam	
Hemocult	
Complete Vision	
Snellen Vision	
Tuberculosis Skin Test (PPD)	
Respirator Fit Testing	
# of masks (check) 1 2 3 4	

Safety Training	
Cardiopulmonary Resuscitation (CPR)	
First Aid Training	
Supervisor Drug and Alcohol Awareness	

Group Treatment Authorization	
Name (First, Last)	
DOB	SS# (Last 4)
Name (First, Last)	
DOB	SS# (Last 4)
Name (First, Last)	
DOB	SS# (Last 4)
Name (First, Last)	
DOB	SS# (Last 4)

NOTE: For groups larger than 4, please request our additional authorization group form.

Special Request:

Phone: (805) 922-8282 **Fax: (805) 925-2690**

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