

  
 **occupational health  
authorization form****Patient Information**

Patient name:	DOB:
Reason for service: <input type="checkbox"/> Employment <input type="checkbox"/> School <input type="checkbox"/> Other	
Signature:	Date:

**Employer Information (if applicable)**

eScreen account # (if applicable):			
Company name:			
Company address:	City:	State:	Zip:
Services scheduled date/time:	Services exp date/time:		
Name and title of person authorizing treatment (please print):			
Signature:	Phone:		
Preferred communication (please check all that apply): <input type="checkbox"/> phone <input type="checkbox"/> fax (secure) <input type="checkbox"/> email (secure) <input type="checkbox"/> mail			
After-hours contact and phone number:			

**DER Information (if applicable)**

DER/Company contact for results and/or physician call:	
DER email:	DER fax:

**Billing Address/TPA (only if different than above)**

Name:			
Address:	City:	State:	Zip:
Phone:	Ext:	Fax:	

# occupational health authorization form (con't)



## Patient Information

Patient name:

DOB:

## Step One (if applicable)

### Check the following:

- Using MedExpress Lab & MRO
- Using Company-Provided Lab & MRO

## Step Two (UDS and BAT only)

### Reason for testing:

- Pre-Employment
- Post-Accident
- Random
- Reasonable Suspicion
- Return to Duty
- Follow up (DOT Return to Duty & Follow up Testing must be observed)

## Step Three

### Please select all services to be performed.

#### DOT Drug/Alcohol Testing:

- DOT Urine Drug Screen (5-Panel only)
- DOT Breath Alcohol Test

Select the modality:

- FMSCA  FTA  FRA  FAA  PHMSA  USCG

#### Non-DOT Drug/Alcohol Testing:

- Rapid Urine Drug Testing  Send out Urine Drug Screen
  - 5-Panel  10-Panel  Custom Panel #

- Breath Alcohol Test
- Hair Collection
  - 5-Panel or  5-Panel w/exp Opiates
- Blood Alcohol (state specific)

#### Physical Examinations:

- DOT
  - New certification  Re-certification
  - Interstate  Intrastate
- Standard Pre-Employment (non-DOT)
- eScreen ePhysical non-DOT look-alike
- Special Company Form (Requires approval - contact your Account Executive)
- Other

### Other Services:

- TB Skin Test
  - 1 Step or  2 Step
- QuantiFERON®-TB Gold Plus
- Communicable Disease Statement
- TD  Tdap
- Hep B Vaccine
  - 1st  2nd  3rd
- Flu Shot
- Point-of-Case Lipid Panel + Glucose

### Labs:

- Blood Draw - Collection Only
- Hep C Titer  Hep B Titer
- MMR Titer  CMP  CBC  Other

### Additional Services (Please call the Outcome Assurance Team to verify 304-985-6324):

- Hep A Vaccine

### Special Instructions:

## Internal Use Only

- Employee did not arrive by the expiration date  Notified/called DER (no show only)  FOA initials:

Athena account #:

### Collect Payment From:

- Employer with active profile  Employer - Pay at time of service  Patient - Pay at time of service
- TPA authorization  WC UDS/BAT - No company profile