

# Concentra®

(Patient Must Present Photo ID at Time of Service)

## Authorization for Examination or Treatment

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_ Location Number: \_\_\_\_\_

Temporary Staffing Agency: \_\_\_\_\_

### Work Related

Injury  Illness

Date of Injury: \_\_\_\_\_

### Substance Abuse Testing\* (check all that apply)

- Regulated drug screen  Breath alcohol
- Collection only  Hair collect
- Non-regulated drug screen  Rapid drug screen
- Other \_\_\_\_\_

### Type of Substance Abuse Testing

- Preplacement  Reasonable cause
- Post-accident  Random
- Follow-up

Special Instructions/comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Authorized by: \_\_\_\_\_

Please print

Phone: (\_\_\_\_\_) \_\_\_\_\_

### Physical Examination

Preplacement  Baseline  Annual  Exit

### DOT Physical Examination

Preplacement  Recertification

### Special Examination

- Asbestos  Respirator  Audiogram
- Human Performance Evaluation\*
- HAZMAT  Medical Surveillance
- Other \_\_\_\_\_

### Billing (check if applicable)

Employee to pay charges

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Title: \_\_\_\_\_

Date