Occupational Medicine — Health Center – Medical Arts

REQUEST FOR SERVICES AUTHORIZATION

TRINITY MEDICAL GROUP

Company:_____

Address:_____

City:_____ State:_____ Zip:_____

DER/Contact:_____

Phone:_____ Email:_____

Fax:_____

Employee Name:_____

SSN:_____

Date of Appointment:_____ Date of Injury/Accident:_____

Type of Injury:_____

Services Requested

- ☐ Initial injury assessment and treatment
- ☐ Follow-up injury treatment
- ☐ DOT physical
- ☐ Non-DOT physical
- ☐ Pre-work screening/lift test
- ☐ Audiogram
- ☐ Pulmonary function test
- ☐ Sleep apnea screen
- ☐ Respirator clearance questionnaire
- ☐ Respiratory mask fit test
- ☐ Vision exam
- ☐ UA dip

Drug Screen Collection

- ☐ Urine
- ☐ Hair

(check one in each column)

- ☐ Federal
- ☐ Non-Federal

- ☐ Pre-employment
- ☐ Random
- ☐ Reasonable suspicion/for cause
- ☐ Post-accident
- ☐ Return to duty
- ☐ Follow-up
- ☐ Other:_____

Breath Alcohol Test

(check one in each column)

- ☐ Federal
- ☐ Non-Federal

- ☐ Pre-employment
- ☐ Random
- ☐ Reasonable suspicion/for cause
- ☐ Post-accident
- ☐ Return to duty
- ☐ Follow-up
- ☐ Other:_____

Other Services/Comments:_____

Services Authorized By:_____

Date:_____ Time:_____

PATIENT LABEL
OR

PATIENT NAME:_____

PATIENT DOB:_____