MEDICAL AUTHORIZATION TO TREAT FORM

Complete listing of clinic locations printed on back

Employer____ **Phone**____________

Patient____ **Date**_____/_____/_____

THIS PATIENT IS AN EMPLOYEE OF OUR COMPANY AND REQUIRES THE FOLLOWING SERVICES:

Medical Services:

❒ Injury Care
❒ Re-check/Re-evaluation
❒ Return to Work Physical
❒ Post Offer Exam
❒ Physical (routine)
❒ CDL/DOT Physical
  ❒ Physical (new)
  ❒ Physical (recertification)
❒ Audiometry
❒ Hepatitis B Injection
❒ Mantoux (TB test)

Drug/Alcohol Testing:

❒ eCup Instant 5-panel drug screen
❒ NIDA/DOT
❒ 5 7 9 10 Panel Drug Screen
circle one
❒ (Collection Only) Drug Screen
❒ Hair Testing
❒ DOT Non-DOT Breath Alcohol Test
circle one

Drug Screen Reasons:

❒ Employment
❒ Random
❒ Reasonable Suspicion
❒ Post Accident
❒ Post Injury
❒ Follow Up

Special Instructions:____

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Authorization expires____________________

Authorized by__________________________________ __________________________________

Print full name please   Signature

Lutheran Health Network Member