Occupational Health Care

Authorization for Treatment Form

Ascent Urgent Care
Ascent Walk-In Clinic

Employee: _____ Date: _____
Last Name First Name Middle Name

Date of Birth : _____ Sex: _____ Age: _____ Phone: _____

Job Title: _____

Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

☐ **WORK RELATED INJURY**
(Specify) _____

☐ **SUBSTANCE ABUSE DRUG SCREEN:**
☐ URINE ☐ HAIR

Type: ☐ DOT ☐ Non-DOT

Reason for Test:
- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Cause
- ☐ Post-Accident
- ☐ Follow-up
- ☐ Post-Injury

☐ **Evidential Breath Testing (Alcohol)**

PHYSICALS:
- ☐ Pre-Employment
- ☐ DOT Initial
- ☐ DOT Recert
- ☐ Return to Work
- ☐ Respiratory Evaluation
- ☐ Injury

Name & Address where to send a Claim:

_____

_____

_____

Note: *Photo ID Required for all Services*

☐ **ILLNESS**
(Specify) _____

☐ **OTHER SERVICES:**

- ☐ Audiogram
- ☐ Back Evaluation
- ☐ Chest X-Ray
- ☐ EKG
- ☐ Hepatitis B Vaccine
  - ☐ Injection # 1
  - ☐ Injection # 2
  - ☐ Injection # 3
- ☐ TB SKIN TEST
- ☐ Pulmonary Function Test (PFT)
- ☐ Tetanus
- ☐ Laboratory Collection

SPECIAL INSTRUCTIONS: (Please Print)

_____

_____

_____

Authorized by: (Signature)

We agree to pay for any medical treatment provided to the above named individual for the checked services.

_____

Phone: _____

Date: _____

☐ HOWELL	☐ SALINE	☐ FENTON
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