Urgent Med

2004 N HWY 81, Duncan Ok. 73533

580-252-1911 (P) 580-252-1020 (F)

AUTHORIZATION FORM

PLEASE MARK **"ALL"** APPLICABLE BOXES & SEND FORM WITH EMPLOYEE

PHOTO ID IS REQUIRED

DATE: _____ **EMPLOYEE:** _____ **SSN:** ___/___/___

DATE OF BIRTH: ___/___/___ **REASON OF VISIT:** _____

EMPLOYER: _____ **PHONE:** (___) _____ **FAX:** (___) _____

DRUG SCREEN: _____ BREATH _____ Test form & kits provided: **YES / NO**

	IN- HOUSE	ALCOHOL		URINE	
		DOT	NON	DOT	NON
*PRE-EMPLOMENT:	☐	☐	☐	☐	☐
***RANDOM:**	☐	☐	☐	☐	☐
***REASONABLE SUSPICION**	☐	☐	☐	☐	☐
*POST ACCIDENT	☐	☐	☐	☐	☐

Dr. Gregston MRO: **YES/NO**

If "IN-House" screen is positive do you want a Chain of Custody recheck? **YES/NO**

Lab? _____

Third party protocol on file with UM **YES/NO**

☐ Bill Employer ☐ Bill third party admin

DER: Name of person to receive results

_____

Fax Number: _____

PHYSICAL OR ADDITONAL SERVICES: **WORK RELATED INJURY:** _____

	DOT	NON-DOT
PRE-EMPLOYMENT	☐	☐
RE-CERTIFICATION	☐	☐

☐ **Initial visit evaluation**

☐ **Follow up visit**

☐ **Return to Work**

☐ **SPIROMETRY**

☐ **X-RAY** _____

☐ **HEARING TEST**

☐ **NURSING PHYSICAL**

EMPLOYER NOTES: _____

_____

_____

EMPLOYER: Please sign below approves requested services & billing procedures for the above named employee:

_____ Please Print Name

_____ Signature

WORK COMP: _____

Phone consent received by UM Staff:

_____

AUTH GIVEN BY : _____

Date: _____ Time: _____