

COLUMBUS REGIONAL HEALTH PHYSICIANS, LLC
Occupational Health Employer Authorization
Patient must present Photo ID and Authorization Form at time of service.

SECTION 1: PATIENT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (MM/DD/YYYY): _____ Social Security Number: _____

SECTION 2: COMPANY INFORMATION

Employer Name: _____ Phone #: _____ Fax #: _____

Primary Contact: _____ E-mail: _____

Address: _____ City, State, Zip: _____

SECTION 3: AUTHORIZED SERVICES (Check all that apply for this visit)

Drug Screening:

- ☐ Urine collection only: ☐ DOT ☐ NONDOT
 - ☐ COC on-site
 - ☐ Donor will bring COC
- ☐ Observed (Additional Fee)
- ☐ Instant Drug Screen
 - ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel
- ☐ Lab Based Drug Screen
 - ☐ 5 Panel ☐ 10 Panel
 - ☐ 7 Panel ☐ 10 Panel no THC
 - ☐ 9 Panel
- ☐ Hair Drug Screen (5 Panel only)
- ☐ Federal / DOT Drug Screen (indicate DOT Agency)
 - ☐ FMCSA ☐ FTA ☐ FAA
 - ☐ FRA ☐ PHMSA ☐ USCG
- ☐ Breath Alcohol Test ☐ DOT ☐ NONDOT

Vaccines:

- ☐ Influenza
- ☐ Tdap
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ MMR
- ☐ Varicella

Labs:

- ☐ Hepatitis B Titer
- ☐ MMR Titer
- ☐ Varicella Titer
- ☐ QuantiFeron Gold (TB)
- ☐ Heavy Metals Panel
- ☐ PPD Skin Test
 - ☐ 2 Step Required

Exams:

- ☐ Pre-Employment Physical Exam
- ☐ DOT Physical Exam
- ☐ Return to Work Physical Exam
- ☐ Lift Test
- ☐ Audiogram
- ☐ Visual Acuity-Snellen
- ☐ Titmus Vision
- ☐ Color Vision-ishi-hara
- ☐ Depth Perception
- ☐ EKG
- ☐ Weight with gear
- ☐ Respiratory Questionnaire Review w/PLHCP
- ☐ Respiratory Fit Test (Respirator/N95 must be provided)
- ☐ Spirometry
- ☐ Consult for Positive PPD Skin Test

Reason for Appointment:

- ☐ Pre-Employment ☐ Reasonable Suspicion ☐ Random ☐ Other: _____
- ☐ Post-Accident / Post Injury ☐ Return to Work ☐ Annual ☐ Other: _____

SECTION 4: WORKERS' COMPENSATION

- ☐ Workers Compensation Injury Treatment ☐ Workers' Compensation Initial Visit Only

Date of Injury: _____ Type of Injury: _____

SECTION 5: CUSTOMER ACKNOWLEDGMENT

EMPLOYER: I hereby authorize the medical provider to treat the named employee above. I acknowledge that all services will be paid for in full by the listed company. Unless stated otherwise in Section 4, this authorization covers both the initial and all necessary follow-up visits. By signing below, I certify the correctness of all information and consent to the stipulated terms.

Employer Authorized Signature (Required) _____ Date _____ Employer Printed Name (Required) _____ Title _____

Form can be faxed or emailed prior to the patient's appointment.

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