500 Cummings Center, Suite 4350
Beverly, MA 01915
Phone (978) 532-2428
Fax (978) 532-0616

Authorization for Medical Services (Basic)

Please have employee bring this form to their appointment* *Must present Photo ID at time of service (license, passport, government ID)

Patient Name: ______________________________ SSN: ______________________

Company Name: ______________________________ Date of Birth: ________________

Location, Street Address: ______________________ Date/Time of Appointment: __________

☐ **Pre-Placement Physical Exam** *Specify Job Position*: ______________________

☐ **DOT Physical Exam** ☐ Pre-Placement ☐ Recertification

☐ **Lift Test** ☐ **Functional Assessment**

☐ **Drug Testing** ☐ **Breath Alcohol Testing**

☐ DOT-Regulated ☐ Non-Regulated

☐ Pre-Employment ☐ Random ☐ Post Accident ☐ Post Injury ☐ Follow-up ☐ Reasonable Suspicion ☐ RTW

☐ Urine, 5 Panel ☐ Urine, 10 Panel ☐ Urine, 10 Panel + Oxycontin ☐ Hair Follicle ☐ Instant

☐ Collection Only ☐ Employee brings Chain of Custody Form

☐ **Work-Related Injury** ☐ **Work-Related Illness** ☐ **Fit-For-Duty Exam**

Ancillary/Other Screenings: (NOTE: Do not Schedule TB Tests on Thursdays)

☐ Travel Medicine Consult ☐ Travel Medicine Vaccines (if required) ☐ EKG ☐ Audiogram

☐ Hepatitis B Vaccine ☐ Hepatitis B Titer (specify, or up to provider discretion) ☐ TB Test

☐ Varicella Titer ☐ MMR Titer ☐ Tetanus ☐ PFT ☐ Resp. Questionnaire

☐ Resp. Fit Test ☐ Other ____

Billing: Invoice Employer ______ Employee Pays at Time of Visit ______ Workers Compensation _____

Date of Injury: ______________________________

Workers Comp Insurance Company: ______________________ PH: __________ FAX: __________
(Name, Address, Phone, Fax)
____

Authorized by: _________________________ **Title:** _________________________

Phone: _________________________ **Date:** _________________________

Employee is authorized to reschedule Appointment? ☐ Yes ☐ No

Schedule by Date: ____________________