Franciscan WORKING Well

MEDICAL TREATMENT AUTHORIZATION

NAOHP CERTIFIED PROGRAM

ALL EMPLOYEES PRESENTING FOR A DRUG SCREEN/BREATH ALCOHOL TEST MUST HAVE A VALID PHOTO ID
FOR AFTER HOURS INJURIES & POST-ACCIDENT/REASONABLE SUSPICION DRUG SCREENS, PLEASE COMPLETE THIS FORM AND PRESENT TO THE EMERGENCY DEPARMENT

EMPLOYEE NAME: _____ DATE OF BIRTH: _____

COMPANY NAME: _____ TODAY'S DATE: _____

COMPANY PHONE: _____ RESULTS: Fax E-Mail: _____

COMPANY REP AUTHORIZING TREATMENT: _____

SIGNATURE: _____VERBAL AUTH TIME: _____ INITIALS: _____

ABOVE EMPLOYEE IS SCHEDULED ON: _____ (Date/Time)

Please mark all that apply:

Purpose for Testing:
- ☐ Pre-employment
- ☐ Random
- ☐ Post-accident
- ☐ Reasonable Cause
- ☐ Follow-up
- ☐ Return to Duty
- ☐ Other_____

Urine Drug Screens:
- ☐ DOT
- ☐ DOT Collection Only

*Specify Testing Agency
- ☐ FMCSA
- ☐ FTA
- ☐ PHMSA
- ☐ FRA
- ☐ FAA
- ☐ USCG

☐ NON-DOT
- ☐ 5 Panel
- ☐ 10 Panel
- ☐ Other: _____

☐ NON-DOT Collection Only

☐ Instant
- ☐ 5 Panel
- ☐ 10 Panel

Breath Alcohol Testing
- ☐ NON-DOT
- ☐ DOT

Hair Drug Screens
- ☐ 5 Panel
- ☐ 5 Panel Expanded
- ☐ Collect Only

Physical Exams
- ☐ DOT
  - ☐ New
  - ☐ Recertification
  - ☐ Follow-Up
- ☐ NON-DOT
- ☐ Return to Work
- ☐ Other: _____

Surveillance Testing
- ☐ Audiogram
- ☐ Lift Test#_____
- ☐ PFT/Spirometry
- ☐ Chest X-Ray
- ☐ Respirator Questionnaire
- ☐ Respirator Fit Test

Type of Mask_____

Injections/Vaccination:
- ☐ PPD/TB Test
- ☐ TDAP
- ☐ Tetanus
- ☐ Hep B
- ☐ Hep A

Titers/Labs:
- ☐ MMR
- ☐ Varicella
- ☐ Hep B
- ☐ Hep C
- ☐ Quantiferon
- ☐ Other_____

Worker's Comp/Injury Treatment

☐ New Injury

Date of Injury: _____

Workers Comp Insurance:

_____

Claim#:

_____

Additional Service Requested:

_____

_____

LOCATIONS:

Munster: 219-836-4690/(F) 219-836-3609
Crown Point: 219-662-5500/(F) 219-662-9684
Valparaiso: 219-464-7073/(F) 219-464-7543
Michigan City: 219-879-5400/(F) 219-879-5900

Hammond: 219-852-2472/(F) 219-852-2567
Rensselaer: 219-866-0411/(F) 219-866-1920
Willowcreek: 219-764-8439/(F)219-764-8463