Franciscan EXPRESSCARE

Franciscan WORKINGWell

# AUTHORIZATION FOR TREATMENT

First Name | Middle Initial | Last Name | Date

Company | Social Security

Company Phone | Company Fax

Company Representative Authorizing Treatment

Work Comp Carrier

**Clinic Address & Phone**

## CHECK SERVICES NEEDED

**Diagnosis & Treatment** ☐ Injury Treatment

**Physical Examination** ☐ DOT ☐ Non-DOT ☐ Pre-placement ☐ Lift Evaluations ☐ Other:

### CHECK TYPE OF DRUG TESTING NEEDED

☐ **Non-DOT** Urine Drug Screen (Chain of Custody)

☐ **DOT** Urine Drug Screen (Chain of Custody)

☐ **Instant Urine Drug Screen** (5-panel or e-Cup) ☐ **Instant Urine Drug Screen** (12-Panel)

☐ **Collection Only** Urine Drug Screen ☐ Non-DOT ☐ DOT ☐ Laboratory

☐ **Breath Alcohol** (BAT) ☐ Non-DOT ☐ DOT

☐ **Hair Analysis**

☐ **Other:**

### CHECK REASON FOR DRUG TEST

☐ Pre-Placement ☐ Random ☐ Reasonable Suspicion / Cause

☐ Post-Accident ☐ Post-Injury ☐ Other

### CHECK ANY ADDITIONAL SERVICES NEEDED *(Note: Call for availability)*

☐ Respirator Questionnaire ☐ Spirometry Testing ☐ Wellness Screenings ☐ Lift Evaluations

☐ Respirator Fit Testing ☐ Audiometric Exams ☐ Vaccinations

☐ Other:

INTERNAL USE ONLY! Verbal Authorization form: Name/Initials (Office / Clinician)

Date: