



AUTHORIZATION FOR EXAMINATION / TREATMENT

*This form is completed by the employer. Patients must present this or equivalent form along with Photo ID to registration staff at front desk.
 To send this form prior to patient's arrival, please fax to ATTN: Registration | 229-312-8190 or email to PCHRegister@phoebehealth.com*

Patient's Name:

Date:

Company Name:

Injury Treatment

Injuries less than 24hrs old must report to clinic ASAP & no later than 5pm Mon-Thu or 3pm Fri. Injuries greater than 24hrs old or treated at ER requires appointment.

Date & Time of Injury
 _____ : _____

Workers' Comp Insurance Carrier

First Report of Injury Claim#

Urine Drug Screen

DOT	Non-DOT
	Collection only
	10 Panel Instant
	5 Panel Instant

Breath Alcohol / EBT

DOT	Non-DOT
-----	---------

Drug Screen

Walk-ins welcome. Call ahead if sending more than 5 employees at one time.

Reason/Purpose

- Pre-employment
- Random
- Post-accident
- Reasonable Suspicion
- Return to Duty (*DOT is observed*)
- Follow up (*DOT is observed*)

Urine Drug Screen

DOT	Non-DOT
	Collection only
	10 Panel Instant
	5 Panel Instant

Breath Alcohol / EBT

DOT	Non-DOT
-----	---------

Hair Collection

Use our CCF	Use your CCF
-------------	--------------

Physical Exam

Appointment required. Call ahead to schedule.

Reason/Purpose

- Post-offer
- Annual / Recertification
- Fit for Duty / Return to work
(requires medical records review prior to appointment)

DOT Physical

Non-DOT Physical

- Respirator Clearance
- HazMat
- Deployment
- Peace Officer (*req. affidavit*)
- School Bus Driver
- Forklift / MEO

Other

Appointment may be required. Call ahead to schedule and verify availability of vaccines.

- Hearing Test / Audiogram
- Tuberculosis Skin Test (PPD)
- Tuberculosis Blood Test (TSpot)
- Pulmonary Function Test (PFT)
- Respirator Fit Test (RFT)
(employee must bring mask)
- Blood draw / Titer (*specify type*)
 - Hepatitis B Titer
 - Other _____
- Vaccines
 - Flu Shot
 - Hepatitis A
 - Hepatitis B
 - Tetanus
 - MMR
 - Other _____
- X-ray (*specify type and rationale*)

Specific Instructions (list additional services needed, type of drug screen, direct observed, send results to..., etc.):

Authorized by
 Title
 Phone