PIVOT
OCCUPATIONAL HEALTH

Authorization for Examination or Treatment

Pivot Location: _____

(Patient Must Present Photo ID at Time of Service)

Company Name: _____ **Today's Date:** _____

Company Contact: _____ **Phone #:** _____

Employee Name: _____ **DOB:** _____

Please check all that apply:

☐ **Work Injury/Workers Compensation**

Date of Injury: _____ Injury Description: _____

Insurance Carrier: _____ Claim #: _____

Physical Examination

☐ Pre-placement ☐ DOT ☐ Periodic/Annual ☐ Exit ☐ Return to Work ☐ Fitness for Duty
☐ Respirator Clearance ☐ Respirator Questionnaire Review Only ☐ Hazmat (Include details below)
☐ Other:_____ Physical Instructions:_____

Substance Abuse Testing

☐ DOT ☐ 5 Panel ☐ 10 Panel ☐ Rapid 5 Panel ☐ Rapid 10 panel
DOT Testing Authority: _____FMCSA _____FAA _____FRA _____FTA _____PHMSA _____USCG
☐ Breath Alcohol ☐ Alcohol Saliva ☐ Other: _____
☐ Collection only—Lab Name: _____ Chain of Custody: ☐ Yes ☐ No

Reason for Substance Abuse Testing

☐ Pre-placement ☐ Post-accident ☐ Random ☐ Reasonable Cause ☐ Follow Up ☐ Return-to-Work

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG ☐ Chest x-ray
☐ Vaccinations:_____ ☐ Blood Work:_____
☐ Other: _____

Special Instructions/Comments: _____

_____

_____

Authorized By: _____ **Signature:** _____