Medical Authorization for Treatment

EMPLOYEE INFORMATION

Date_____ Company Name_____

Name of Employee_____ Plant Location_____

Employee Birthdate_____ Employee SSN_____

Employee Job Title_____

Reason for Visit/Services Desired – Please Check all that Apply

- ☐ Worker's Comp/Injury ❶
- ☐ Physical Exam – DOT ❷
- ☐ Physical Exam – Pre-Employment ❸
- ☐ Breath Alcohol ❹
- ☐ PT/OT Evaluation and Treatment ❺
- ☐ X-Ray ❽
- ☐ Urine Drug Screen (UDS) ❻
  - ☐ UDS Post-Accident
  - ☐ UDS Random
  - ☐ UDS Reasonable Suspicion
  - ☐ UDS Pre-Employment
- ☐ Hair Follicle Drug Screen ❼
- ☐ Other Services (vaccinations, etc.) please indicate_____

Please Indicate the Location for Services *(Please note that not all services are available at all locations.)*

☐ Memorial Health Employer Services
695 W. 2nd Street, Suite A1
Jasper, Indiana
812.996.5750
Services: ❶❷❸❹❻❼❽

☐ Memorial Orthopaedic Associates
695 W. 2nd Street, Suite A2
Jasper, Indiana
812.996.5950
Services: ❶❽

☐ Memorial Rehabilitation Services
695 W. 2nd Street, Suite D
Jasper, Indiana
812.996.0682
Services: ❺

☐ Huntingburg Urgent Care
507 E. 19th Street
Huntingburg, Indiana
812.683.4717
Services: ❶❽

☐ Memorial Hospital Emergency Department
800 W. 9th Street
Jasper, Indiana
812.996.2345
Services: ❶❹❻❽

☐ Memorial Hospital Laboratory
800 W. 9th Street
Jasper, Indiana
812.996.2345
Services: ❹❻

☐ Other Services or Locations Not Listed: _____

_____

_____

MEMORIAL HOSPITAL
And Health Care Center
Sponsored by the Little Company of Mary Sisters - USA
800 West 9th Street ▲ Jasper, IN 47546 ▲ 812/996-2345
www.mhhcc.org

INJURY INFORMATION

Site and Description of Employee Illness/Injury_____

_____

Date of Injury_____ Time of Injury_____

Claim #_____

COMPANY CONTACT INFORMATION

Contact Name Tracy Troesch Contact Phone Number 812-817-0900 option #5

Contact Fax Number 812-367-1075

Company Address 432 E 15th St

City Ferdinand State IN Zip Code 47532

I authorize the above employee to be treated for the services/injury/illness noted above and I assume responsibility for the charges incurred.

Tracy Troesch, business mgr _____

Company Contact/Authorized Personnel Signature Date

EMPLOYEE/PATIENT AUTHORIZATION TO RELEASE

I, the undersigned, herby consent to the test(s) noted above for all visits/referrals related to the injury noted above. By signing, I hereby authorize Memorial Hospital and Health Care Center and any attending and/or consulting providers to release return to work information regarding my medical treatment for this injury to my employer and the insurance and/or worker's compensation carrier for which I have assigned benefits for my treatment and care, and to my referring and any other health care provider or facility responsible for my care, if they request it. I will not hold my company, my worker's compensation carrier, any health care provider, medical personnel, hospital, medical center, or clinic legally responsible for the release or use of the physical examination report and/or test results. I agree to accept responsibility for all charges incurred should my employer or insurance plan refuse to pay. I understand a urine or hair follicle analysis will include a test to find out if there are substances in my body that a health care provider did not prescribe and/or illegal substances in my urine or hair. I understand that if I refuse to take any or all of the test(s) noted above, or if I refuse to sign this consent form, the test(s) will not be completed. I also understand that my company will be notified of my refusal. This could result in rejection of my application for employment, rejection of temporary labor services, and/or loss of employment.

_____ _____

Employee/Patient Signature Date

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