

## AUTHORIZATION FOR EXAMINATION OR TREATMENT

PATIENT NAME: \_\_\_\_\_

Social Security#: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WORK RELATED: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

### SUBSTANCE ABUSE TESTING

Regulated Drug Screen

Collection Only

Non-Regulated Drug Screen

### TYPE OF SUBSTANCE ABUSE TESTING

Preplacement

Post - Accident

Follow-Up

Reasonable Cause

Random

### PHYSICAL EXAMINATION

Preplacement

Baseline

DOT Physical Examination

Asbestos

Respirator

Fit Test

HAZMAT

Audiogram

Medical Surveillance

Due to the nature of these specific services, only the patient and staff are allowed in the testing treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanied by them to the medical center.

Special Instructions:

Authorized by: \_\_\_\_\_

*Please Print*

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

9201 SUNSET BLVD., M-155, WEST HOLLYWOOD, CA 90069

310-273-1155

**FAX AUTHORIZATION PRIOR TO SENDING EMPLOYEE TO: 310-271-7759**

**FROM THE LOBBY LEVEL TAKE THE ELEVATOR MARKED MEZZANINE TO THE**

**LOWER LEVEL – Only 1 bank of elevators services the Mezzanine**

**JOHN FOSTER, MD**