



Occupational Medicine
Work Safe. Work Smart.
managed by NovaCare

(Patient must present photo ID at the time of service)
Authorization for Examination or Treatment

Patient Name: _____ Patient SSN: _____
DR. License State & No. (Required for DOT-FMCSA Testing): _____ Date of Birth: _____
Employer's Name: _____ Employer's Address: _____
Worker's Compensation Injury Care: Injury _____ Date of Injury _____
Affected Body Part(s): _____
Claim #: _____ Insurance Carrier: _____

Substance Abuse Testing (DOT) *

WORKNET DOT 5 Panel Collection only
Breath Alcohol DOT
***Reason for test- DOT (if above testing is checked, please select one)**
Pre-Employment Reasonable Suspicion
Random Follow-up Other (please specify):
Post-Accident Return to Duty
Periodic (USCG Only) Direct Observation

Physical Examinations

Post offer Annual
DOT Post offer DOT Recertification
OSHA Respirator HAZMAT
Fitness for Duty Return to work

***DOT Agency Required:** FMCSA FTA FAA PHMSA FRA USCG

Substance Abuse Testing (Non-DOT) **

Collection only Hair Collection
WORKNET 5 Panel (Lab) WORKNET 10-panel (Lab)
WORKNET (other Panel-Lab)
Instant 5-panel Instant 11-panel
Breath Alcohol Non-DOT
**** Reason for test-NON DOT (if above testing is checked, please select one)**
Pre-Employment Reasonable Suspicion
Random Follow-up
Post-Accident Post- Injury
Fitness for Duty Per Company Request
Return to Work

Other Medical Services

Audiogram Vaccine – Hepatitis B
Lift Testing/POET Vaccine – Hepatitis A
EKG Vaccine – TDAP
Spirometry Vaccine – Flu
Respirator Fit Test Vaccine:
Vision Screening
PPD (TB clearance) – 2 step protocol
PPD (TB clearance) - 1 step protocol
Chest X-Ray (TB clearance)
Titer - Varicella Blood Lead with ZPP
Titer – MMR Titer – Hepatitis B

Other services not listed above or special instructions for authorization:

Billing: Employee pays for services Bill the employer account for services

Required

Authorized By: _____ Title: _____
Phone: _____ Email: _____ Date: _____

CLICK ON THE DROPDOWN BOX FOR A LIST OF EMAIL ADDRESSES TO SEND THIS FORM TO:

“Your submission of this form to Select Medical will not be secured by Select Medical. Your default email client will be used to submit this completed form back to us; please ensure that the solution you are using to send this email is secure”