



## Authorization for Examination or Treatment

Patient Must Present Photo ID at Time of Service

All services will be conducted in accordance with your company's existing protocols on file at Nevada Occupational Health Center unless otherwise specified. Company specific forms must be presented at time of service or our standard forms will be utilized. See our website for more information and printable forms at [www.NVOHC.com](http://www.NVOHC.com).

DATE OF AUTHORIZATION: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ AUTHORIZED BY: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_ LOCATION NUMBER: \_\_\_\_\_

PHONE: \_\_\_\_\_ Fax or Email: \_\_\_\_\_

*Please mark all that apply.*

EMPLOYER PAY

EMPLOYEE PAY

WORK INJURY

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

SUBSTANCE ABUSE TESTING :

*Reason for testing:*

Pre-placement  Reasonable Cause

Post Accident  Random

*Type of testing:*

Regulated  Non-Regulated

Urine  Breath Alcohol

Hair Collect  Rapid Test

SPECIAL INSTRUCTIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICAL EXAMINATION:

Pre-employment

Annual

DOT physical

Other: \_\_\_\_\_

SPECIAL EXAMINATION:

Respirator Medical Clearance

Respirator Fit test

Pulmonary Function Test

Audiogram

Lift test

TB Skin Test

T-spot or Quantiferon Gold (For Tuberculosis)

Other \_\_\_\_\_