SANFORD HEALTH

Occupational Medicine
3838 12th Ave. N.
Fargo, ND 58102
(P) (701) 234-4700
(F) (701) 234-4757

Authorization for Examination or Treatment

EMPLOYER is to mark all services required.

Patient Name: LAST _____ FIRST _____ MI _____

DOB: _____ / _____ / _____

Company

Name: _____

Address: _____

_____ _____ _____
City State Zip

Work Related

*Please indicate in Substance Abuse Testing section if drug AND/OR alcohol screen is required post accident.

INJURY/SCREENING INFORMATION

Physical Examination:
Select One:

DOT Medical Card Exam
_____ Preplacement Physical*
_____ Recertification Physical

* If Drug Screen is also required please mark right side

Exam
_____ Preplacement Job Title_____
_____ Annual / Periodic
_____ Other:_____

Special Exam
_____ Asbestos
_____ Respirator
_____ Medical Surveillance

Additional Testing
_____ Audiogram
_____ HPE
_____ Pulmonary Function Test
_____ Respirator Fit Test
_____ SFT
_____ TB / Mantoux Test / PPD
_____ Other:_____

Substance Abuse Testing (Drug test)
***(Photo ID Required)**
Select One:

Reason for Screen:
_____ Annual
_____ Follow-up (Non-Regulated)
_____ Follow-up - DOT (Observation required)
_____ Insurance
_____ Post accident/injury
_____ Pre-employment
_____ Random
_____ Reasonable suspicion
_____ Return to Duty (Non-Regulated)
_____ Return to Duty - DOT (Observation required)

Select One:

Drug Screen Type:
_____ DOT Urine Drug Screen (Regulated)
☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
_____ Non-Regulated Urine Drug Screen
_____ Non-Regulated Urine Rapid Screen
_____ Hair Collection

Alcohol Screen Type:
_____ DOT Breath (Regulated)
_____ Non-Regulated Breath
_____ Non-Regulated Blood

Billing Information (select one):

_____ Bill Company
_____ Third Party Administrator _____
_____ Employee to pay charges
_____ Worker's Comp _____

Special Instructions: _____

Authorized by: _____ Phone:_____ Date:_____ Time:_____
(MUST BE SIGNED)