

Total

Occupational Medicine

3333 Drusilla Lane Suite B
Baton Rouge, LA 70809

PHONE (225) 924-4460

FAX (225) 927-0547

MEDICAL AUTHORIZATION FORM DATE: _____

Send the form with your employee or fax it to: (225) 927-0547

EMPLOYEE NAME: _____ JOB/PO# _____

COMPANY NAME: _____ PHONE# _____

COMPANY ADDRESS: _____ FAX# _____

CITY, STATE, ZIP CODE _____

<input type="checkbox"/> <u>PHYSICAL EXAMS</u> <input type="checkbox"/> DOT Physical <input type="checkbox"/> Non-DOT <input type="checkbox"/> Hazardous Waste <input type="checkbox"/> Benzene <input type="checkbox"/> Asbestos <input type="checkbox"/> Operators Other: _____ <u>REASON FOR TEST</u> <input type="checkbox"/> Pre-Placement <input type="checkbox"/> Annual <input type="checkbox"/> Return to Work	<input type="checkbox"/> <u>INJURY</u> <input type="checkbox"/> Work Comp <input type="checkbox"/> General <input type="checkbox"/> Liability <u>WorkComp CarrierName</u> _____ <u>Phone#</u> _____ _____	<input type="checkbox"/> <u>URINE DRUG SCREEN</u> <input type="checkbox"/> DOT (CDL) <input type="checkbox"/> Non-DOT <input type="checkbox"/> DOT Collection <input type="checkbox"/> Non-DOT Collection <input type="checkbox"/> Quick Screen <input type="checkbox"/> <u>ALCOHOL TESTING</u> <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Breath REASON FOR TEST <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Annual <input type="checkbox"/> Random <input type="checkbox"/> Post-Accident <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Other: _____	<input type="checkbox"/> <u>TEST</u> <input type="checkbox"/> Audiogram <input type="checkbox"/> Pulmonary <input type="checkbox"/> Respirator Fit Type of Mask _____ <input type="checkbox"/> Chest X-Ray(1 view) <input type="checkbox"/> Chest X-Ray(2 view) <input type="checkbox"/> EKG <input type="checkbox"/> Lumbar X-Ray (2views) <input type="checkbox"/> Lumbar X-Ray(3 views) <input type="checkbox"/> Lumbar X-Ray (5views) <input type="checkbox"/> Eye Exam Only <input type="checkbox"/> Other: _____ _____ _____
<u>LABORATORY TEST</u> <input type="checkbox"/> INDUSTRIAL CHEM <input type="checkbox"/> CBC <input type="checkbox"/> Lead Blood <input type="checkbox"/> ZPP (Zinc) <input type="checkbox"/> HIV Other: _____ _____ _____	<u>INJECTIONS</u> <input type="checkbox"/> Flu Vaccine <input type="checkbox"/> Hepatitis B Vaccine <input type="checkbox"/> Tetanus Shot <input type="checkbox"/> TB Skin Test Change ok per: <input type="checkbox"/> Other: _____ _____ _____		

Office Use Only: Initials
FD _____
DS _____
N/NT _____

AUTHORIZED BY: _____ ***TITLE OF PERSON*** _____

(PRINT NAME) _____ ***REQUIRED***