

Authorization for Treatment

SECTION ONE: To be completed on all referrals

Employee (Patient) Name _____

Company Name & Phone # _____

On the Job Injury: _____ Date of Injury: _____

SECTION TWO: To be completed for ON THE JOB INJURIES

W/C Insurance Carrier: _____ Phone #: _____

Adjustor name: _____ Phone #: _____

Date of Injury: _____ Claim #: _____

Submit medical expenses to company Submit medical expenses to insurance carrier

SECTION THREE: Check all requested services

Screenings

- Urine Drug Screen - DOT
- Urine Drug Screen - Non-DOT Panel _____
- Urine Drug Screen - Quick Test
- Breath Alcohol Testing – DOT
- Breath Alcohol Testing – Non-DOT
- Audiogram
- Pulmonary Function Testing (PFT)
- Respiratory Mask Fitting
- Color Vision Screening
- DOT/FMCSA Physical Exam
- Pre-Employment Physical
- Physical Exam: _____
- X-ray: _____
- Electrocardiogram
- Lift/Strength Test/Essential Job Function
- Hair Collection

Immunizations

- Hepatitis A
- Hepatitis B
- Influenza
- MMR Vaccine
- Chickenpox Vaccine
- Pneumonia Vaccine
- Tetanus/Diphtheria/Pertussis
- Rabies/Meningitis/Polio
- Travel Health
- TB Skin Test
- Lab Titers: MMR - Chickenpox - Hep B
Q-Gold (TB) - Hep A
- Injury Care
- Fire Fighter/Police Physicals
- Fit for Duty Physicals
- MEO Physicals
- Other: _____

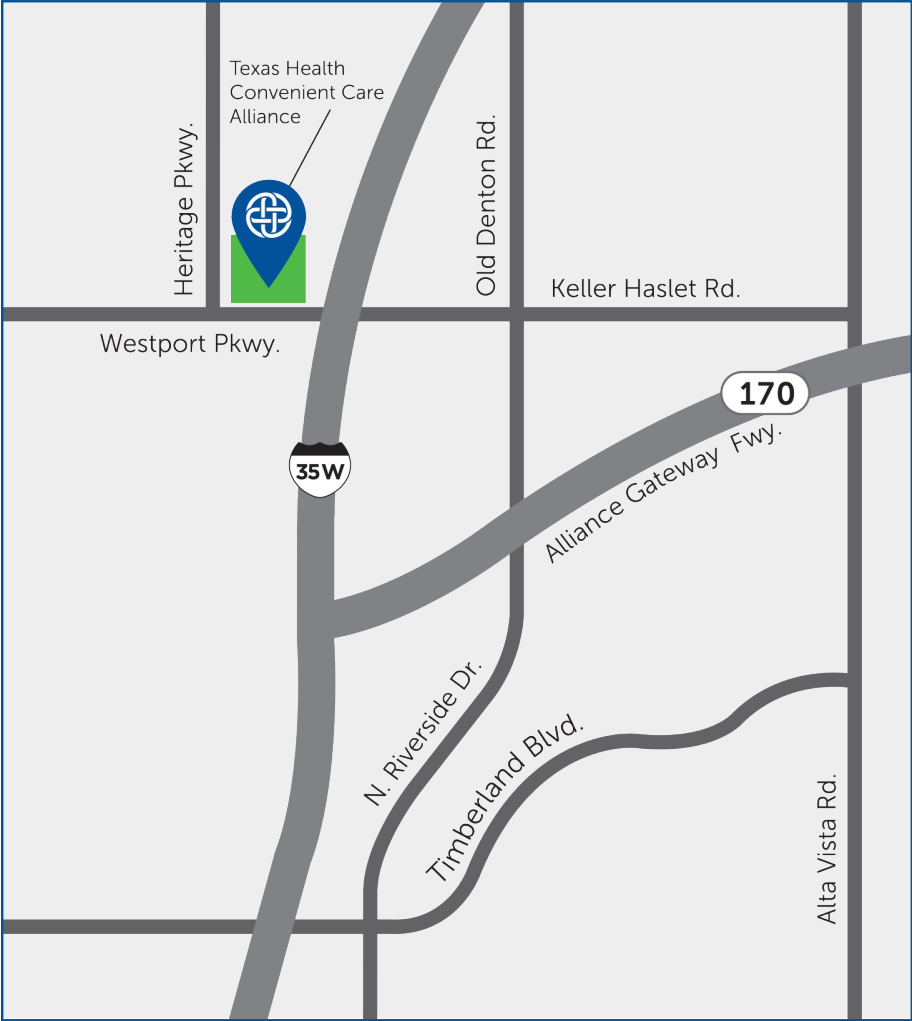
SECTION FOUR: To be completed on all referrals

Authorized by (Name and Title): _____

Phone #: _____ Date: _____

Additional Comments: _____

PHOTO ID REQUIRED



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