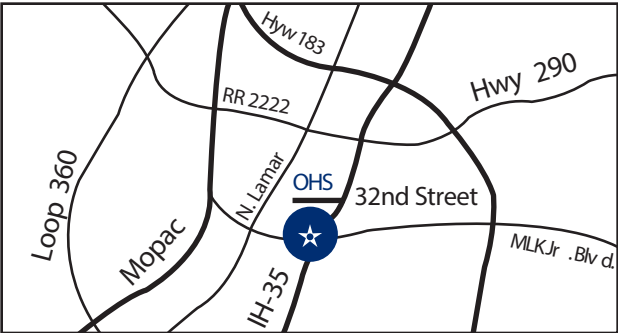



918 E. 32nd Street · Austin, TX 78705
Phone 512.544.8195 · Fax 512.544.8285

Hours: Monday-Friday 8am - 4:30pm

EMPLOYER AUTHORIZATION FOR EXAMINATION OR TREATMENT

| | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Employee Name: | | Date of Birth: | | | |
| Company Name: | | | | | |
| Work Related <input type="checkbox"/> Injury/Illness <input type="checkbox"/> Evaluation <input type="checkbox"/> Exposure Date of Injury: _____ | | Physical Examination <input type="checkbox"/> Pre-placement <input type="checkbox"/> Annual <input type="checkbox"/> DOT <input type="checkbox"/> Surveillance _____ | | | |
| Drug and Alcohol Testing Photo Identification Required <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <u>Testing Situation</u> <input type="checkbox"/> Pre-placement <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Annual <input type="checkbox"/> For Cause </td> <td style="width: 50%; border: none; vertical-align: top;"> <u>Test</u> <input type="checkbox"/> DOT <input type="checkbox"/> 5-Panel <input type="checkbox"/> 9-Panel <input type="checkbox"/> 10-Panel <input type="checkbox"/> Rapid Drug Screen <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Hair Testing <input type="checkbox"/> Health Care Worker Panel of Abuse <input type="checkbox"/> Steroid Panel </td> </tr> </table> <input type="checkbox"/> Collecti on Only <input type="checkbox"/> Chain of Custody (COC) on file at OHS | | <u>Testing Situation</u> <input type="checkbox"/> Pre-placement <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Annual <input type="checkbox"/> For Cause | <u>Test</u> <input type="checkbox"/> DOT <input type="checkbox"/> 5-Panel <input type="checkbox"/> 9-Panel <input type="checkbox"/> 10-Panel <input type="checkbox"/> Rapid Drug Screen <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Hair Testing <input type="checkbox"/> Health Care Worker Panel of Abuse <input type="checkbox"/> Steroid Panel | Special Testing <input type="checkbox"/> Audiogram <input type="checkbox"/> Respirator Clearance Questionnaire <input type="checkbox"/> Respirator Fit Testing - Quantitative (PortaCount) <input type="checkbox"/> PFT (Pulmonary Function Test) <input type="checkbox"/> Vision Titmus <input type="checkbox"/> Agility Test <input type="checkbox"/> Other: _____ | |
| <u>Testing Situation</u> <input type="checkbox"/> Pre-placement <input type="checkbox"/> Random <input type="checkbox"/> Post Accident <input type="checkbox"/> Annual <input type="checkbox"/> For Cause | <u>Test</u> <input type="checkbox"/> DOT <input type="checkbox"/> 5-Panel <input type="checkbox"/> 9-Panel <input type="checkbox"/> 10-Panel <input type="checkbox"/> Rapid Drug Screen <input type="checkbox"/> Breath Alcohol <input type="checkbox"/> Hair Testing <input type="checkbox"/> Health Care Worker Panel of Abuse <input type="checkbox"/> Steroid Panel | | | | |
| | | Immunizations/Titers/TB Testing <input type="checkbox"/> Tspot <input type="checkbox"/> TB Blood Test <input type="checkbox"/> TB/PPD <input type="checkbox"/> HEP B <input type="checkbox"/> HEP A <input type="checkbox"/> Flu <input type="checkbox"/> Tdap <input type="checkbox"/> Varicella <input type="checkbox"/> MMR <input type="checkbox"/> Other: _____ | | | |
| Billing <input type="checkbox"/> Bill Company <input type="checkbox"/> Bill Workers' Compensation <input type="checkbox"/> Employee to pay charges at time of service Special Instruction/Comments: | | | | | |
| Authorized By: Signature | | Date: | | | |
| Print Name: | | | | | |
| Phone: () | | Fax: () | | | |
| Directions 918 E. 32nd Street · Austin, TX 78705  <p>Parking On Site</p> | | Emergency Rooms <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p> St. David's Medical Center 919 East 32nd Street Austin, TX 78765 512.476.7111</p> <p>St. David's Georgetown Hospital 2000 Scenic Dr. Georgetown, TX 78628 512.943.3000</p> <p>St. David's Round Rock Medical Center 2400 Round Rock Ave. Round Rock, TX 78681 512.341.1000</p> </div> <div style="width: 48%;"> <p>St. David's North Austin Medical Center 12221 N. MoPac Expy. Austin, TX 78758 512.901.1000</p> <p>St. David's South Austin Hospital 801 W. Ben White Austin, TX 78704 512.447.2211</p> </div> </div> | | | |