Adult & Pediatric Urgent Care
WWW. APURGENTCARE.COM

(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: _____ Date of Birth: _____

Street Address: _____ Location Number: _____

Temporary Staffing Agency: _____

Work Related

❑ Injury ❑ Illness

Date of Injury _____

Substance Abuse Testing★ (check all that apply)

❑ Regulated drug screen ❑ Breath alcohol

❑ Collection only ❑ Hair collect

❑ Non-regulated drug screen ❑ Rapid drug screen

❑ Other _____

Type of Substance Abuse Testing

❑ Preplacement ❑ Reasonable cause

❑ Post-accident ❑ Random

❑ Follow-up

Physical Examination

❑ Preplacement ❑ Baseline ❑ Annual ❑ Exit

DOT Physical Examination

❑ Preplacement ❑ Recertification

Special Examination

❑ Asbestos ❑ Respirator ❑ Audiogram

❑ Human Performance Evaluation★

❑ HAZMAT ❑ Medical Surveillance

❑ Other _____

Billing (check if applicable)

❑ Employee to pay charges

Special instructions/comments: _____

_____

_____

_____

★ Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: _____ Title: _____
Please print

Phone: (_____) _____ _____
Date