1702 Ohio Ave
Lynn Haven, FL 32444

COASTAL URGENT CARE

Ph: (850) 571 – 5844
Fax: (850) 571 – 5845

Authorization for Services

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Social Security Number:** _____

Company Name: _____

Please indicate below which services we are to provide:

☐ **Drug Screens** *(Please ensure you have selected a form, test, agency if DOT, and reason for test)*:

Form (**MUST SELECT ONE**):

☐ Coastal's Chain of Custody Form

☐ Your Company's Chain Of Custody *(Must be provided to donors by your company unless kept on file with us)*

Test (**MUST SELECT ONE**): ☐ DOT (**MUST** Select Agency below) ☐ 10 Panel DFWP ☐ Rapid (Instant)

If DOT Drug Screen, Select Agency: ☐ FMSCA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐USCG

Reason for Screening (**MUST SELECT ONE**): ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Post Accident ☐ Return to Duty ☐ Follow-Up ☐ Other:

☐ **Pre-employment Physical** ☐ **DOT Physical** ☐ **FDLE Physical** ☐ **OSHA Resp Physical** *(Not for masks)*

☐ **Vaccinations:** ☐ Hep B ☐ Flu ☐Other Vaccinations *(Specify)*:

☐**Pulmonary Function Test** *(Only PFT)* ☐ **Audio Testing** ☐ **Vision**

☐ **TB / PPD Testing** *(Two visits with 48-72 hrs between)* ☐**Chest X-rays** ☐ **EKG**

☐ **Additional Services** *(Specify)***:**

Portion below for Work Comp Treatment ONLY

☐ **Workers Compensation Injury**:

Please Select One of the following: ☐ Provide Medical Treatment and Drug Testing
☐ Provide Medical Treatment Only ☐ Provide Drug Testing Only

Date of Injury: _____

Injury to (Body Part): _____

Work Comp Insurance Carrier Name: _____

Address: _____

City: _____ State: _____Zip:_____

Phone: _____ Fax: _____

Authorizing Information

Contact Name (please print): _____

Title / Position in Company: _____

Authorized Signature: _____