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COASTAL URGENT CARE

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# Authorization for Services

**Patient Name:** ______________________________ **Date:** ______________

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

**Company Name:** ________________________________________

Please indicate below which services we are to provide:

## Drug Screening

Drug Screen Type
- ☐ Rapid (Instant)
- ☐ 10 panel DFWP (Non-DOT)
- ☐ DOT
  DOT Agency: ____________

Reason for Screening
- ☐ Pre-employment
- ☐ Random
- ☐ Post Accident
- ☐ Other: ______________

Form
- ☐ Coastal's Chain of Custody
- ☐ Employer's Chain of Custody

## Physical Exam

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

## Vaccinations

- ☐ Hep B (3 shot series over 6 months)
- ☐ Flu
- ☐ TDAP
- ☐ Other Vaccine: ____________________

## Other Services

- ☐ Pulmonary Function Test (PFT)
- ☐ Audio Testing
- ☐ Visual Acuity
- ☐ Ishihara Visual Exam
- ☐ TB Testing (2 visits, 48 hrs between)
- ☐ Chest Xrays
- ☐ EKG
- ☐ Other: ____________________

## Workers Compensation Injury Treatment

☐ **Workers Compensation Injury**:

Date of Injury: ____________________ Claim Number: ____________________

Injury to (Body Part): ________________________________________

Work Comp Insurance Carrier Name: ________________________________________

Address: ________________________________________

City: ____________________ State: __________ Zip: __________

Phone: ____________________ Fax: ____________________

**Authorizing Information (Form not valid if this section not complete!)**

Contact Name (please print): ________________________________________

Title / Position in Company: ________________________________________

Contact Phone Number: ________________________________________

Authorized Signature: ________________________________________