CORPORATE CARE
OCCUPATIONAL MEDICINE

Authorization/Referral Form

3100 Windsor Ct. • Elkhart, IN 46514
Ph: 574-266-6555 • Fax: 574-266-6888

420 N. Main St. • Middlebury, IN 46540
Ph: 574-825-3400 • Fax: 574-825-3424

Patient Name _____ Date _____

Birth Date _____ S S # _____

Company Name _____

Authorized by:

Print _____ Signature _____

TREATMENT REQUEST

[ ] PATIENT PAY [ ] COMPANY PAY

[ ] DOT Physical	[ ] Industrial Physical Pre-Placement	[ ] PFT
[ ] Respirator Approval	[ ] Respirator Fit Testing	[ ] Audiogram
[ ] W/C Initial	[ ] W/C Follow Up	[ ] TB/Mantoux
[ ] Hep B Vaccine	[ ] Tetanus	[ ] Other _____

DRUG AND ALCOHOL TEST

[ ] OBSERVE [ ] DO NOT OBSERVE

[ ] DOT Drug Test	[ ] Saliva Alcohol Test	[ ] Breath Alcohol Test
[ ] Urine Collection Only	[ ] Hair Test	[ ] Oral Drug Screen

[ ] Rapid Drug Screening (choose panel below)

[ ] 4 Panel	[ ] 5 Panel	[ ] 6 - 10 Panel

REASON FOR TEST

[ ] Pre-Placement [ ] Post-Accident [ ] Reasonable Cause [ ] Random

Picture ID Required For Drug Test

Map on Reverse Side