

Patient Treatment Authorization

Arrowood Medical Center - Occumed at Riverview - Riverview Medical Center

Date _____ Time _____ AM PM Patient Name _____

Please treat the above patient for the following services... (check all that apply)

- Injury/Accident Date of Injury _____ Date Employee Last Worked _____
Injured Body Part _____
Occurred at _____ County _____
- Return-to-Work Evaluation (Notes and release from patient's treating physician are required.)
- Physical Abilities Test (PAT)
- Physical Exam Pre-Placement Annual Re-Certification Other _____
Type... Basic (Non-DOT)
 DOT
 Respirator Clearance with Respirator Fit without Respirator Fit
 Special Company Protocol _____

Drug and/or Alcohol Testing (please check below)

Type of Test	Reason for Drug/Alcohol Testing
<input type="checkbox"/> Breath Alcohol Test	<input type="checkbox"/> Pre-Placement
<input type="checkbox"/> 5-Panel Urine Drug Screen (Non-DOT)	<input type="checkbox"/> Random
<input type="checkbox"/> 5-Panel Urine Drug Screen (DOT)	<input type="checkbox"/> Post-Accident
<input type="checkbox"/> 5 Panel Urine Drug Screen (Non-DOT - Rapid Test) (2-hour turn-around for negative results)	<input type="checkbox"/> Post-Injury
<input type="checkbox"/> 9-Panel Urine Drug Screen (Non-DOT)	<input type="checkbox"/> Return-to-Duty
<input type="checkbox"/> Urine Drug Screen Collection Only (Non-DOT) (Set up directly with lab - Use company's paperwork.)	<input type="checkbox"/> Follow-Up
<input type="checkbox"/> Urine Drug Screen Collection Only (DOT) (Set up directly with lab - Use company's paperwork.)	<input type="checkbox"/> Reasonable Suspicion
<input type="checkbox"/> 5-Panel Hair Drug Screen	<input type="checkbox"/> Court-ordered
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____

Photo ID is required!!

- Other Services:**
- TB Skin Test/PPD
 - Hepatitis B Vaccine
 - Audiogram
 - Other _____

.....

Treatment authorized by: (Name and Title) _____

Does employee work for a temporary staffing company? Yes No If yes, who? _____

Company _____ Dept./Location (if applicable) _____

Company Contact for results and/or physician call _____

Prefer communication via (please check all that apply) phone fax e-mail mail

Address _____ City _____

State _____ Zip Code _____ e-mail _____

Phone () _____ Ext. _____ Fax () _____ check if confidential fax

.....

Billing address (only if different than above): Company or WC Insurance Carrier _____

Address _____ City _____ State _____ Zip _____

Attn: _____ Phone () _____ Fax () _____

If billing to carrier: Policy # _____ Effective Dates of Policy ___/___/20__ to ___/___/20__

Locations and Hours of Operation

1 Arrowood

MEDICAL CENTER

9720 South Tryon Street
Charlotte, NC 28273
704.588.7362
704.588.9127 fax

Open 8 am - 6 pm
Monday through Friday

Open 9 am - 5 pm
Saturday

Riverview is available for care after hours - 24 hours a day.

2 Riverview

MEDICAL CENTER

1393 Celanese Road
Rock Hill, SC 29732
803.329.3103
803.327.7937 fax

Open 24 hours
Seven days a week

2 Occumed

AT RIVERVIEW

1393 Celanese Road
Rock Hill, SC 29732
803.327.0033
803.325.2232 fax

Open 8 am - 8 pm
Monday through Friday

Riverview is available for care after hours - 24 hours a day.

