

Patient Treatment Authorization

Arrowood Medical Center ■ Occumed at Riverview ■ Riverview Medical Center

Patient Name _____ Date _____ Time _____ AM PM

Authorization Expires on: _____

Company _____ Location (if multiple sites) _____

Does employee work for a temp agency? Yes No If yes, who? _____

Treatment authorized by: Name and Title (please print) _____

Signature _____ Phone () _____

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

Injury/Accident Date of Injury _____ Date Employee Last Worked _____
Injured Body Part _____

Drug and/or Alcohol Testing (Please check type and reason below)

Type of Test

Using our lab and MRO

- Breath Alcohol Test (Please check DOT or Non-DOT)
- 5-Panel Urine Drug Screen (Non-DOT)
- DOT Urine Drug Screen (Expanded 5-Panel)
Please check one... FMCSA FAA FRA
 FTA PHMSA USCG
- Rapid Urine Drug Screen (Non-DOT)**
(Please check 5-panel or 10-panel)
(2-hour turn-around for negative results)
- 9-Panel Urine Drug Screen (Non-DOT)
- 10-Panel Urine Drug Screen (Non-DOT)
- Hair 5-Panel Drug Screen**

OR

Using your company paperwork, lab and MRO

- Collection Only**
Urine Drug Screen
 DOT
 Non-DOT
- Collection Only**
Hair Drug Screen
- Using Your Rapid Kit**
Rapid Urine Drug Screen
 5-panel
 9-panel 10-panel
 Other _____

Reason for Drug/Alcohol Testing

- Pre-Placement
- Random
- Post-Accident
- Post-Injury
- Return-to-Duty
- Follow-Up
- Reasonable Suspicion
- Job Specific
- Other _____

Photo ID is required!!

Physical Examination

- DOT (Please check New Certification or Re-Cert or Follow-Up)
- Pre-Placement Basic (Non-DOT)
- Annual*
- Respirator Clearance with Fit Test* without Fit Test
- Return-to-Work Evaluation*
(Notes and release from patient's treating physician are required.)
- Special Company Protocol* _____
- Other _____
*Appointment Required

Other Services:

- Physical Abilities Test (PAT)*
- TB Skin Test/PPD One Step Two Step
- Hepatitis A Vaccine
- Hepatitis B Vaccine Dose 1 Dose 2 Dose 3
- Audiogram
- Flu Vaccine
- Blood Lead Level
- Titmus Vision
- Ishihara 14-plate Color Vision
- Other _____
*Appointment Required

RESULTS: Company Contact and/or physician call _____

Preferred communication (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 _____

Phone () _____ If billing WC Carrier: Claim # _____

WC Adjuster or Nurse Case Manager: _____ Ph: _____ Fx: _____

Locations and Hours of Operation

1 Arrowood

MEDICAL CENTER

9720 South Tryon Street
Charlotte, NC 28273
704.588.7362
704.588.9127 fax
facebook.com/arrowoodmed
www.arrowoodmed.com

Open 7am - 7pm
Monday through Saturday

2 Riverview

MEDICAL CENTER

1393 Celanese Road
Rock Hill, SC 29732
803.329.3103
803.327.7937 fax
facebook.com/riverviewmed
www.riverviewmed.com

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
www.riverviewmed.com

Open 7:30am -5pm
Monday through Friday

