Concentra

*(Patient Must Present Photo ID at Time of Service)*

# Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: Saint Louis University Employee Health Date of Birth: _____

Street Address: 3547 Olive Street Phone Number: _____

**Work Related**

☐ Injury ☐ Illness

Date of Injury: _____

**Physical Examination**

☐ Preplacement ☐ Baseline ☐ Annual ☐ Exit

***Substance Abuse Testing*** Check all that apply

**For Post AUTO accident testing, choose Regulated Drug Screen and Breath Alcohol.**

☐ Regulated drug screen ☐ Breath Alcohol
☐ Collection only ☐ Hair Collect
☐ Non-regulated drug screen ☐ Rapid drug screen
☐ Other: _____

**DOT Physical Examination**

Preplacement Recertification

**Special Examination**

☐ Asbestos ☐ Respirator ☐ Audiogram
☐ Human Performance Evaluation
☐ Hazmat ☐ Medical Surveillance
☐ Other: _____

**Type of Substance Abuse Testing**

**Please select reason for testing**

☐ Preplacement ☐ Reasonable cause
☐ Post-Auto accident ☐ Random
☐ Follow-up

**Billing (check if applicable)**

☐ Employee to pay charges

**Special Instructions/comments:**

_____

_____

_____

_____

Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert you employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

**Authorized by:** _____ **Title:** _____

Please print

**Phone:** _____ **Date:** _____