WORK PARTNERS
OCCUPATIONAL HEALTH SPECIALISTS

AUTHORIZATION FOR SERVICES OR TREATMENT

Patient Name: _____ Date: _____

Please note that a valid photo ID is required for all services.

Employer: _____ Telephone: _____

Authorized by: _____ Signature: _____

WORK INJURY TREATMENT

Work Comp Carrier: _____

Claim Number: _____

Does this injury require a Drug Screen? ☐ Yes ☐ No If Yes, ◯ DOT ◯ Non-DOT

Does this injury require a Breath Alcohol Test? ☐ Yes ☐ No If Yes, ◯ DOT ◯ Non-DOT

NON-INJURY SERVICES

☐ Physical Exam

☐ DMV / DOT Physical

DRUG SCREEN

☐ DOT Drug Screen

☐ Non-DOT Drug Screen

BAT BREATH ALCOHOL TEST

☐ DOT BAT

☐ Non-DOT BAT

☐ Audiogram

☐ Livescan Fingerprinting

☐ TB Skin Test

☐ TB Blood Test

☐ Titer: _____

☐ Vaccine: _____

☐ Other: _____

SPECIAL INSTRUCTIONS: _____

_____

_____

The difference is how we treat you.

WorkPartnersOHS.com

☐ OCEANSIDE
3156 Vista Way, Ste. 100
Oceanside, CA 92056

760 681 5222
760 681 5151 f

☐ VISTA
2365 S. Melrose Drive
Vista, CA 92081

760 571 5910
760 597 0349 f