WorkPartners
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

Does this injury require a Breath Alcohol Test? ❍ Yes ❍ No

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 Test: Quantiferon Gold

❍ Titer: ____________________

❍ Vaccine: ____________________

❍ Other: ____________________

SPECIAL INSTRUCTIONS: ____________________

The difference is how we treat you.

WorkPartnersOHS.com

❍ OCEANSIDE
2122 S. El Camino Real, Ste. 100
Oceanside, CA 92054

760 681 5222
760 681 5151 f

❍ VISTA
2365 S. Melrose Drive
Vista, CA 92081

760 571 5910
760 597 0349 f