WorkPartners™

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: Body Part Injured: Left ☐ Right ☐

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 Blood Test: TSPOT

☐ Titer: _____

☐ Vaccine: _____

☐ Other: _____

SPECIAL INSTRUCTIONS:

_____

_____

_____

OCEANSIDE
3156 Vista Way, Suite 100
Oceanside CA 92056-3608

phone: 760.681.5222
fax: 760.681.5151

VISTA
2365 S. Melrose Drive
Vista CA 92081-8788

phone: 760.571.5910
fax: 760.597.0349

MISSION VALLEY
7485 Mission Valley Rd., Suite 100
Mission Valley CA 92108-4422

phone: 619.900.1330
fax: 619.431.3653

NATIONAL CITY
1510 Sweetwater Road, Suite B
National City CA 91950

phone: 619.552.2870
fax: 619.768.2596

The difference is how we treat you.

WorkPartnersOHS.com