State of Maryland

Authorization for Examination or Treatment

(Patient Must Present Photo ID at Time of Service)

Agency:_____ **Today's Date**:_____

(List Agency or Sub-Agency to Receive Invoice) **Appointment Date/Time/Location** (if applicable):

_____

Agency Location:_____ **Authorized By**:_____

Agency Phone No.:_____ **Agency Fax No**:_____

Employee:_____ **Employee Date of Birth**:_____

Please check all that apply:

☐ **Work Injury/Illness** Date of Injury_____ Claim# (if available) _____

Physical Examination

☐ Pre-placement ☐ Pre-placement w/ Ergonomic Assessment ☐ DOT– Regulated (Recert ONLY)

☐ Fitness for Duty/Ability to Work ☐ Medical Surveillance ☐ FAA - MDOT

☐ Initial Workability ☐ Follow-up Workability ☐Other: _____

Substance Abuse Testing

☐ DOT - Regulated Drug Test ☐ Non-regulated Drug Test *(a.k.a. MDOT Drug Test)*

☐ DOT – Regulated Alcohol (Breath) ☐ Non-regulated Alcohol Test (Saliva) *(a.k.a. MDOT Alcohol Test)*

☐ Other: _____ ☐ Direct Observation Required

Reason for Substance Abuse Testing

☐ Pre-employment ☐ Reasonable Suspicion ☐ Post-accident ☐ Random

☐ Follow-up ☐ Return to Duty ☐ Other _____

Psychological Services

Please Provide Employee/Applicant Phone # and Zip Code -AND- DAC's Email Address*

☐ Psychological Testing (Psych Eval) ☐ SAP ☐ Critical Incident Management

Other Services

☐ Respirator Fit Test ☐ Audiogram ☐ PPD ☐ Pulmonary Function Test ☐ EKG

☐ Chest X-ray ☐ Vaccinations:_____ ☐ Other:_____

Special instructions/comments_____

_____

For WORKPRO and PIVOT Occupational Health locations and hours, visit www.PivotOccHealth.com