Work Wellness

TREATMENT AUTHORIZATON

PATIENT TO BRING THIS FORM

Occupational Medicine
Injury Care
First Aid
Injury Prevention
Health Promotion Program
DOT (DMV) Physicals
Pre-employment Physicals
Annual Screening Physicals
Urine Drug Screening
Breath Alcohol Testing
Audiology Screening
Spirometry Testing
HAZMAT Screening

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Office Hours:
Monday - Friday
8:00am - 5:00pm

Mike Romeo, MD
Carrie Janiski, DO
Michael Lawrence, OEH-ANP
Dr. Jenny Wong, DO
Dr. Daniel, DO
Briana Luna, PA-C

Date _____ Date of Injury _____

Employee _____

Employer _____

Insurance Carrier _____

Phone Number _____ Policy Number _____

Treatment Authorization Signature _____

Treatment Authorization Printed Name _____

Phone _____ Fax _____

MEDICAL TREATMENT REQUESTED: (EXPLAIN IF APPROPRIATE)

□ INJURY CARE: (explain) _____

□ DMV PHYSICAL □ PRE EMPLOYMENT/ ANNUAL BASIC PHYSICAL

□ AUDIO □ SPIRO/ PULMONARY FUNCTION □ FIT MASK TESTING

□ PPD □ IMMUNIZATION: _____

□ URINE DRUG SCREEN: □ DOT □ NON DOT

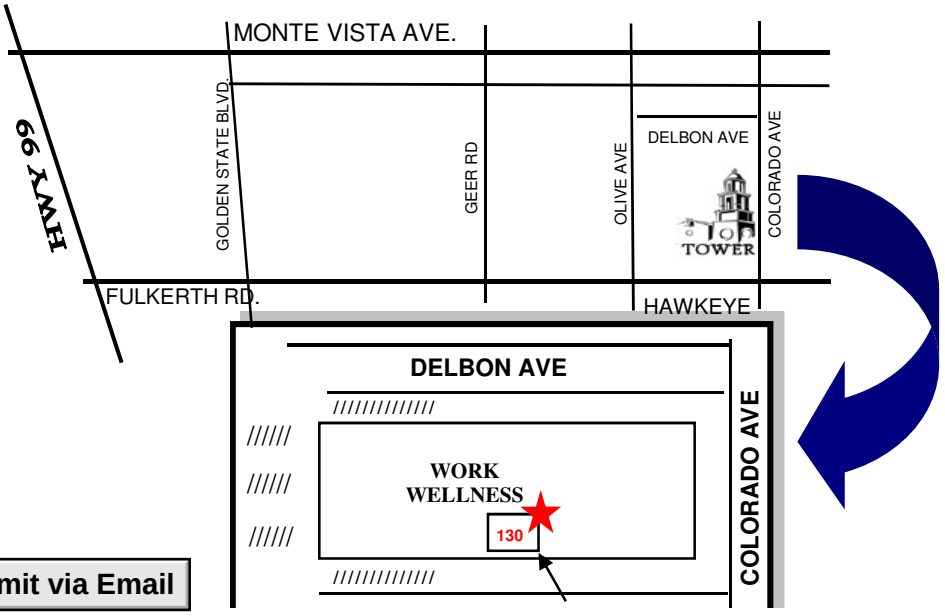
□ HAIR COLLECTION

□ ALCOHOL SCREEN □ DOT □ NON DOT

(please select reason for test)
□ PRE EMPLOYMENT
□ POST ACCIDENT
□ RANDOM
□ REASONABLE SUSPICION
□ OTHER: _____

□ OTHER: _____

TURLOCK



Submit via Email

By submitting this form, you the employer, are authorizing treatment for above employee and agree to the terms and conditions of treatment and payment of services.