Authorization for Occupational Health Services

Company Name: _____ Today's Date: _____

Employee Name: _____ Date of Birth: _____

PHYSICAL EXAMS

Drug screens are not automatically part of the physical exam process. If a drug screen is needed, please request it separately.

☐ DOT ☐ Work Injury ☐ Pre-Placement (Job descriptions may be requested.)
☐ FAA ☐ Tuberculosis ☐ Return to Work
☐ Disability Exam ☐ Independent Medical Exam (IME)
☐ OSHA Surveillance (Please list what type(s) of Surveillance): _____
☐ Performance Evaluation/Work Capacity (Must supply own function test evaluation form, unless already on file.) This service is performed in our Rehabilitation Services department.
☐ Other (please explain): _____

DRUG AND ALCOHOL TESTING SERVICES [Check what test(s) your company is requesting.]

Reason for Drug and/or Alcohol Test:

☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion/Cause ☐ Return to Duty ☐ Follow-Up
☐ Post-Accident ☐ Other (Specify): _____

Drug Test:

☐ **Option 1: Collection Only** Chain of Custody (COC)/MRO/Lab provided by the company, lab, or third party administrator
☐ Non-DOT/Non-Federal Drug Screen ☐ DOT/Federal Drug Screen (If DOT, specify DOT Agency.)
☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG

☐ **Option 2: Full Service** (Olmsted Medical Center's contracted lab, MRO and results sent to your company)
☐ Non-DOT/Non-Federal Drug Screen ☐ DOT/Federal Drug Screen (If DOT, specify DOT Agency.)
☐ 5 Panel (Default) ☐ 11 Panel ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG
☐ 4 Panel (No THC) ☐ 10 Panel (No THC)

Alcohol Test:

☐ DOT/Federal BAT (Breath Alcohol Test) ☐
☐ Non-DOT Breath Alcohol Test (BAT) (Positive BAT for Non-DOT will be confirmed with a blood alcohol test.)
☐ Non-DOT Blood Alcohol Test

OTHER SERVICES (Check what services your company is requesting.)

☐ Audio Screen
☐ Chest X-ray (Requires physical exam)
☐ OSHA Labs (Lead, Arsenic, Cadmium, Mercury)
☐ Quantiferon TB
☐ Respiratory Form Review
☐ Respiratory Fit Test (Qualitative)
☐ Pulmonary Function Test/Spirometry
☐ TST/PPD (Tuberculosis skin test)
☐ Hepatitis A Vaccine
☐ Hepatitis B Vaccine
☐ Influenza (Flu) Vaccine
☐ MMR Vaccine
☐ Rabies Vaccine
☐ TD or TDaP Vaccine
☐ Varicella Vaccine
☐ Hepatitis A Titer
☐ Hepatitis B Titer
☐ Hepatitis C Titer
☐ MMR Titer
☐ Rabies Titer
☐ Varicella Titer
☐ Other Services Not Listed (Please specify.): _____

RESULTS (Please indicate where you would like exam and test results sent.) ☐ Encrypted Email or ☐ Secure Fax

Email Address: _____

Secure Fax#: _____

(Fax machine is maintained in a manner that ensures privacy by restricting access to authorized personnel only.)

Contact Person: _____ Phone: _____

Name of authorized person completing form: _____ **Phone #:** _____

Signature: _____ **Date:** _____

Please e-mail the completed form to occappt@olmmed.org or fax to 507.292.7001.
Send a copy with your employee to the appointment.