

Authorization for Treatment



URGENT CARE

& OCCUPATIONAL MEDICINE

4221 S. Alameda St. Vernon, CA 90058

(Parking on corner of S. Alameda & 43rd St.)

Tel 323.676.5111 Fax 323.676.5112 info@LAUrgentCare.net

OPEN 8am-5pm Mon-Fri & Sat by Appointment

AUTHORIZATION FOR TREATMENT

Employee: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Authorized By: _____

Title: _____

W.C. Carrier: _____ Self-Insured? Yes: _____ No: _____

Today's Date: _____ Time: _____

Injury Date: _____ Injury Time: _____

WORK INJURY OR PHYSICAL:

- Work Injury Treatment - (Indicate drug screen below if required)
- Physical - Post Offer
- Physical - Fit for Duty / Return to Work
- DOT / DMV
- PPD - TB Test
- Other: _____

DRUG SCREEN TO PERFORM OR INCLUDE:

- eScreen 5 Panel
- eScreen 10 Panel
- DOT
- Other: _____

REASON FOR DRUG SCREEN: (Required)

- | | |
|-----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Post Accident | <input type="checkbox"/> Post-Offer |
| <input type="checkbox"/> Follow-Up | <input type="checkbox"/> Return to Duty |
| <input type="checkbox"/> Reasonable Suspicion | <input type="checkbox"/> Random |

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