

AUTHORIZATION FORM

Patient Must Present Photo ID at Time of Service

Company: _____ Date: _____

Authorized By: _____ Phone: _____

Patient Name: _____

Date of Birth: _____

Please check all boxes that apply:

WORK RELATED:☐ Injury Date of Injury: _____**DRUG SCREEN:****TYPE:** ☐ DOT ☐ Non-DOT Urine (send to lab)(Specify DOT Agency: ☐ FMCSA ☐ FAA ☐ FRA ☐ FTA ☐ PHMSA ☐ USCG)☐ Rapid Urine ☐ 5-Panel ☐ 5-Panel, no THC ☐ 9-Panel ☐ 10-Panel ☐ 10-Panel, no THC☐ Collection Only (use company chain of custody form)**REASON FOR TESTING:** ☐ Pre-Placement ☐ Random ☐ Follow Up ☐ Post Accident ☐ Reasonable Suspicion**BREATH ALCOHOL SCREEN:****TYPE:** ☐ DOT ☐ Non-DOT**REASON FOR TESTING:** ☐ Pre-Placement ☐ Random ☐ Follow Up ☐ Post Accident ☐ Reasonable Suspicion**PHYSICAL EXAMINATION:**☐ Pre-Placement ☐ Annual ☐ Respirator ☐ Other**DOT EXAMINATION:**☐ Pre-Placement ☐ Re-Certification**IMMUNIZATIONS:**☐ Hep A ☐ Hep B ☐ Flu ☐ Varicella ☐ Tetanus ☐ MMR ☐ Other**OTHER:**☐ Pulmonary Function Test ☐ TB Skin Test ☐ TB Quantiferon Gold ☐ Audiogram ☐ Functional Screen☐ Labs: _____

Please write in any services requested that are not listed above:

BETTENDORF

4487 53rd Ave

563-421-0640

Fax: 563-421-0649

GHS_GOH-Bettendorf@mercyone.org**CLINTON**

915 13th Ave North

563-244-5742

Fax: 563-243-7288

DAVENPORT

1520 W 53rd St

563-421-3840

Fax: 563-421-3849

GHS_GOH-Davenport53rd@mercyone.org**MOLINE**

2526 41st St

309-281-2700

Fax: 309-281-2709

GHS_GOH-Moline@mercyone.org