

Request for Treatment

Grace Medical Clinic
1208 Brook Ave
Wichita Falls, TX 76301
Phone: (940) 761-3333 Fax: (940) 766-6302

EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT
(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

PATIENT/EMPLOYEE NAME: _____ SSN: _____
COMPANY NAME: _____ DATE OF BIRTH: _____
PATIENT/EMPLOYEE PHONE #: _____ DATE OF INJURY: _____

WORK-RELATED:

INJURY **ILLNESS**

Post Accident Substance Abuse Testing:

- Drug Screen
- Breath Alcohol

TEST TYPE:

- DOT Regulated
- Non-DOT

BILLING

- Bill company for services
- Employee to pay at time of service
- Bill Workers' Compensation Carrier
- Carrier: _____
- Policy #: _____
- Phone #: _____
- Address: _____
- Claim #: _____

PHYSICAL EXAMINATIONS/SERVICES

- Job Title: _____
- DOT Pre-placement
 - DOT Recertification
 - Physical Examination (non-DOT)
 - Pulmonary Function Test
 - Hazmat
 - MDA
 - Audiogram
 - Lab Work _____
 - Hep A Immunization
 - Hep B Immunization
 - Influenza Vaccination
 - Tetanus Immunization
 - X-ray _____
 - TB test
 - EKG
 - Vision Testing
 - Other: _____

TEST TYPE:

- Pre-placement
- Annual
- Exit

SUBSTANCE ABUSE TESTING:

- Regulated (DOT)
 - Non-Regulated (non-DOT)
 - e-Screen (Instant)
 - Hair Collection
 - Breath Alcohol
- TEST TYPE:** (Please check reason)
- Pre-placement
 - Random
 - Reasonable Suspicion
 - Post Accident
 - Periodic
 - Follow-up
 - Return to Duty
 - Observed

EMPLOYER WILL GUARANTEE PAYMENT FOR SERVICES RENDERED. ANY BILLING CHANGES WILL INCUR AN ADDITIONAL FEE.

Authorized by: _____ Title: _____

Phone: _____ Date: _____