Occupational and Industrial Medicine
520 Griffin Avenue
Valdosta, GA 31601
T: 229-433-7300 F: 229-433-7333

AUTHORIZATION FOR TREATMENT OR EXAMINATION (MUST PRESENT PHOTO ID UPON VISIT). DUE TO FEDERAL GUIDLINES, WE CAN NO LONGER TAKE AN EMPLOYEE DESCRIPTION OVER THE TELEPHONE.

PATIENT NAME: _____ **DOB:** _____

COMPANY NAME: _____ **SSN#:** _____

COMPANY ADDRESS: _____

IF THIS IS AN ER AFTER HOURS VISIT, PLEASE USE CELL PHONE FOR DRUG/ALCOHOL SCREEN ONLY, AT 229-561-2063 IN ORDER TO SPEED UP CARE.

CHECK TYPE OF CARE ☐ WORKERS COMPENSATION INJURY CARE DRUG/ ALCOHOL TESTING ☐ BILL COMPANY NOT WORKERS COMPENSATION INSURANCE FOR INJURY CARE

*********MUST HAVE THE FOLLOWING INFORMATION FOR INJURY CARE***********

DATE OF INJURY: _____ **TIME OF INJURY:** _____

SUBSTANCE ABUSE TESTING PLEASE CHECK APPROPRIATE LINE	PLEASE CHECK APPROPRIATE LINE	PLEASE CHECK APPROPRIATE LINE	PLEASE CHECK APPROPRIATE LINE
____ 5 PANEL QUICKSCREEN ____10 PANEL QUICKSCREEN ____DOT DRUG SCREEN ____5 PANEL NON DOT DRUG SCREEN ____7 PANEL NON DOT DRUG SCREEN ____ 10 PANEL NON DOT DRUG SCREEN ____DOT SALIVA ALCOHOL ____DOT BREATH ALCOLHOL ____NON DOT SALIVA ALCOHOL ____NON DOT BREATH ALCOHOL ____NICOTINE ____HAIR COLLECTION	____ PLEASE SEND QUICKSCREEN RESULTS TO LAB, IF NON NEGATIVE FOR DRUGS, FOR CONFIRMATION. ____DO NOT SEND QUICKSCREEN TO LAB, IF NON NEGATIVE FOR DRUGS. ____PLEASE SEND NICOTINE RESULTS TO LAB IF NON NEGATIVE.	____USE COMPANY FORMS ____NO FORM AVAILABLE, USE OCCUPATIONAL AND INDUSTRIAL MEDICINE CENTER FORMS AND MRO	____PRE PLACEMENT ____RANDOM ____POST ACCIDENT ____REASONABLE SUSPICION ____RETURN TO DUTY ____MONITORED DRUG SCREEN ____DIRECT OBSERVED DRUG SCREEN **NOTE: ALL PATIENTS WITH NON NEGATIVE QUICKSCREEN UNDER WORKERS COMP CLAIMS ARE SENT TO LAB FOR CONFIRMATION.**

PHYSICAL EXAMS

PLEASE CHECK APPROPRATE LINE

____DOT PRE-PLACEMENT	____ DOT RECERTIFICATION	____ PAE (PHYSICAL ABILITIES EXAM)
____NON DOT PRE-PLACEMENT	____ STRENGTH TEST	____ AUDIOGRAM
____RESPIRATOR QUESTIONAIRE	____ PFT	____HEP B VACCINE
____FIT FOR/ RETURN TO DUTY	____ EYE EXAM	____HEP B TITER

AUTHORIZED BY: _____ **PHONE:** _____

DATE: _____ **TIME:** _____ **SECURE FAX:** _____

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Phone: 229-433-7300 Fax: 229-433-7333

Employer: _____

Phone Number: _____ Fax Number: _____

Mailing Address: _____

_____

_____

Billing Address: _____

_____

_____

Contact Person and Phone Number: _____

Send Results To: _____

Workman's Compensation Insurance Information

Insurance Company Name: _____

Insurance Company Address: _____

_____

_____

Phone Number: _____ Fax Number: _____

Contact/ Representative: _____

Josh Edmondson: Accounts Manager
Phone: 229-433-7306 Fax: 229-433-7333
Email: josh.edmondson@sgmc.org