AdventHealth Centra Care

AUTHORIZATION FOR SERVICES

Employee / Applicant: _____

Company Name: _____

Company Address: _____

[X] Corporate Bill

[ ] Self Pay

Worker's Compensation

- [ ] Injury Treatment
- [ ] Post Accident Drug Screen
  - [ ] DOT
  - [ ] Florida DFWP
  - [ ] Non-regulated
- [ ] Post Accident Alcohol Testing
  - [ ] DOT Breath Alcohol
  - [ ] Florida DFWP Blood Alcohol
  - [ ] Non-regulated
    - [ ] Breath
    - [ ] Blood

NOTE: *DOT post-accident testing requires breath alcohol. DFWP requires blood*

Prescription Dispensing Program:

May we fill W/C Prescriptions on-site? [ ] Yes [ ] No

Alcohol Testing *

- [ ] DOT Breath Alcohol Test
- [ ] Non-DOT Breath Alcohol Test
- [ ] DFWP Blood Alcohol
- [ ] Non-Regulated Blood Alcohol

Urine Drug/Alcohol Screening *

Reason for test

- [ ] Pre-employment
- [ ] Random
- [ ] Reasonable Cause
- [ ] Post Accident
- [ ] Return to Duty
- [ ] Follow-up

Observed Collection ** Yes ____ No ____

Urine Drug Screens *

- [ ] Collection only
  - [ ] Forms/kits on file in center
  - [ ] Employee will bring in form/kit
- [ ] Florida Drug Free Workplace
  - [ ] 5 Panel
  - [ ] 8 Panel
  - [ ] 10 Panel
- [ ] DOT/FAA Drug Screen
- [ ] Hair Drug Screen

Exams

- [ ] Physical Exam
  - [ ] Annual/Perodic
  - [ ] Pre-employment
- [ ] DOT Physical Exam
  - [ ] Annual/Perodic
  - [ ] Pre-employment
- [ ] Respiratory Physical
- [ ] Other: _____
- [ ] Osha Questionairre

Occupational Testing

- [ ] Spirometry - Pulmonary Function
- [ ] Audiometry
- [ ] Titmus
- [ ] Flu Shot
- [ ] PPD - TB Screening
- [ ] Hep Screening (HBSAB)
- [ ] Hepatitis B Vaccine
- [ ] EKG
- [ ] OTHER:

Additional Notes/Comments:

* *Requires Photo Identification*

** *Observed specimen collections require supporting documentation and can only be ordered under specific conditons*

Authorized by: _____ Date: _____ Phone: _____

Phone Auth From: _____ Received by: _____ Date: _____ Time: _____