Franciscan WORKING Well

1704 Lafayette Rd., Suite 1
Crawfordsville, IN 47933 **(765) 362-6374**

AUTHORIZATION FOR TREATMENT

EMPLOYEE NAME: _____ SS# _____

COMPANY NAME: _____

COMPANY PHONE #_____ FAX # _____

Company Representative Authorizing Treatment (print name): _____

Company Representative Authorizing Treatment (e-mail): _____

Company Representative Signature: _____ Phone # _____

The above employee is scheduled on: Date: _____ Time: _____

Check Services Needed

Diagnosis & Treatment ☐ Injury Treatment

Physical Examination ☐ DOT ☐ Non-DOT ☐ Pre-placement ☐ Other:_____

Check Type of Drug Testing Needed

☐ **Non-DOT** Urine Drug Screen (Chain of Custody)

☐ **DOT** Urine Drug Screen (Chain of Custody)

☐ **Instant Urine Drug Screen** (5-panel) ☐ **Instant Urine Drug Screen** (12-panel) ☐ **Other:**_____

☐ **Collection Only** Urine Drug Screen ☐ Non-DOT ☐ DOT ☐ Laboratory:_____

☐ **Breath Alcohol** ☐ Non-DOT ☐ DOT

☐ **Hair Analysis** ☐ **Other:**_____

Check Reason For Drug Test

☐ **Reasonable Suspicion / Cause** *(Select one of the following: Post Accident, Injury or Other)*

☐ Pre-Placement ☐ Random ☐ Post-Accident ☐ Post-Injury ☐ Other:_____

Check Any Additional Services Needed *(Note: Call for availability.)*

☐ Respirator Questionnaire ☐ Spirometry Testing ☐ Wellness Screenings ☐ Lift Evaluations

☐ Respirator Fit Testing ☐ Audiometric Exams ☐ Vaccinations

☐ Other:_____

INTERNAL USE ONLY Verbal Authorization from:

WW Signature:_____ Date: Time: