FIRSTCHOICE
Occupational Health

Medical Treatment Authorization

Patient Name _____ Occupation _____ Today's Date _____

Company Name _____ Phone Number _____

Services Requested

- ❑ Work Related Injury / Illness
- ❑ DOT Exam
- ❑ Return to Work Physical
- ❑ Pre-Placement Exam
- ❑ X-Ray: _____
- ❑ Drug Screen ❑ *DOT* ❑ *Non-DOT*
- ❑ Breath Alcohol Test ❑ *DOT* ❑ *Non-DOT*

Drug Screen/Breath Alcohol Reason for Testing:

- ❑ Return to Duty
- ❑ Pre-Employment
- ❑ Random
- ❑ Post Accident
- ❑ Follow Up
- ❑ Reasonable Suspicion/Cause

Note - Photo ID required for all drug tests

- ❑ Fit For Duty Evaluation
- ❑ Respirator Clearance
- ❑ Back Assessment
- ❑ Audiogram (Hearing Test)
- ❑ Pulmonary Function Test (Lungs)
- ❑ Electrocardiogram (EKG)
- ❑ TB Test
- ❑ Immunization: _____
- ❑ PAT/JCT/EFT: _____
- ❑ Other: _____

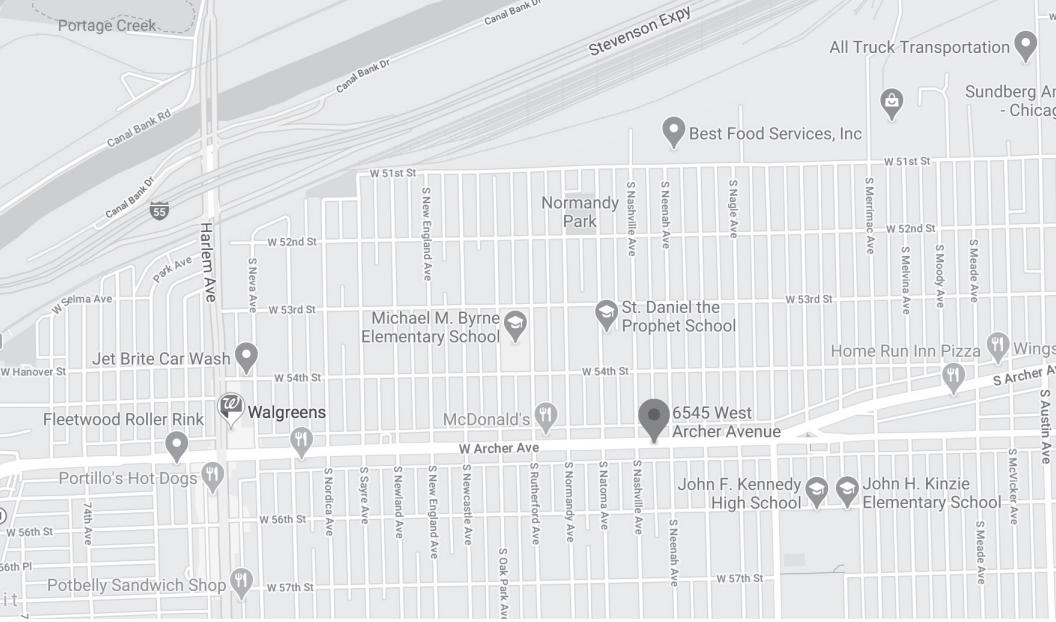
Special Instructions: _____

_____

Company Authorization By: _____ **Title:** _____

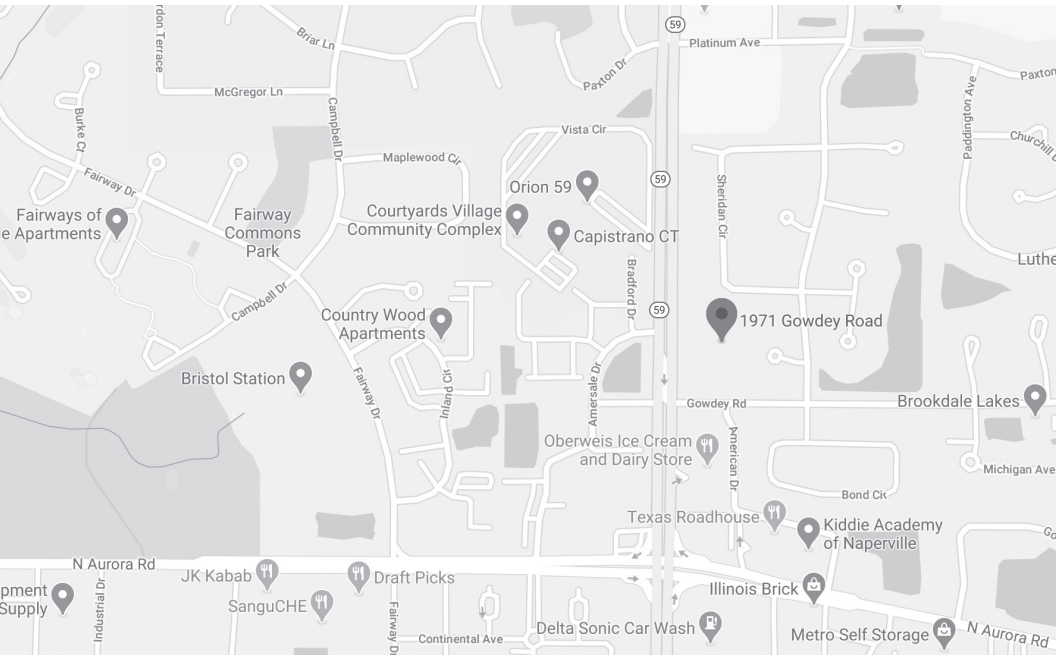
Print Name Here: _____

Appointment Date: _____ **Time:** _____



Chicago Clinic: *6545 W Archer Ave, Chicago, IL. 60638*
Office: 630-974-6131
Fax: 630-974-6313

HOURS
6AM-1AM, Monday-Friday



Naperville Clinic: *1971 Gowdey Road, Naperville, IL. 60563*
Office: 630-416-7293
Fax: 630-416-1511

HOURS
8AM-6PM, Monday-Friday