Saddleback Family & Urgent Care

vituity® At the heart of better care.

# AUTHORIZATION FOR MEDICAL SERVICES

Today's Date: _____ Employee Name: _____

Company Name: _____ Company Phone: _____

Company Address: _____ Authorized By: _____

**Office Use only** (telephone authorization received by): _____

**Insurance Information: (Workers Compensation Only)**

Insurance Carrier: _____ Policy number: _____

Date of Injury: _____ Protocol on file: Yes _____No _____

***If Drug Screen and/or BAT are needed with treatments, please write it under "SPECIAL INSTRUCTIONS" below.**

**Physicals: (Occupational Medicine)** **Monday – Friday**

*Check the box for the services needing to be rendered. Protocol on file: Yes _____ No _____

☐ Work Related Physical ☐ DOT/DMV Physical ☐ Other: 1. _____
2. _____
3. _____
4. _____

**Drug Screening: (Occupational Medicine & Workers Compensation)**

**Reason for Drug Screen:** ☐ Pre-Placement ☐ DOT/DMV ☐ Random ☐ Return to Duty ☐ Post-Accident

☐ Follow-Up ☐ Reasonable Suspicion

**Type of Test:** ☐ Breath Alcohol Test (BAT) NIDA ___ Non-NIDA ___

☐ Non-NIDA, Standard 5 panel ☐ Non-NIDA, Special Panel (Please specify) _____

☐ NIDA-5 PANEL SPLIT ☐ eCup, Panel _____ ☐ xCup, Panel _____

**Processing Instructions for Staff:** _____ **Collect sample and send to:** _____

**Special Instructions:**

_____

_____

_____

_____

**23962 Alicia Parkway, Suite I-1**
**Mission Viejo, CA 92691**
**Tel: (949)452-7699**
**Fax: (949)770-2815**