Southern Plains Medical Group

Excellence, Every Patient, Every Time

(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Employer: _____ Employer Phone Number: _____

Billing Address: _____

Patient Name: _____ Social Security Number: _____

Work Related

☐ Injury ☐ Illness

Date of Injury _____

Substance Abuse Testing (check all that apply)

☐ DOT drug screen ☐ Breath Alcohol

☐ Collection Only ☐ Hair collect

☐ Non-DOT regulated drug screen ☐ Rapid drug screen

☐ Other _____

Type of Substance Abuse Testing

☐ Preplacement ☐ Reasonable cause

☐ Post-accident ☐ Random

☐ Follow-up

Special instructions/comments: _____

_____

_____

_____

Physical Examination

☐ Preplacement ☐ Baseline ☐ Annual ☐ Exit

DOT Physical Examination

☐ Preplacement ☐ Recertification

Special Examination

☐ Asbestos ☐ Respirator ☐ Audiogram

☐ HAZMAT ☐ Medical Surveillance

☐ Other _____

Billing (check if applicable)

☐ Employee to pay charges

☐ Employer to pay charges

* Due to the nature of these specific services, only the patient and staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: _____ Title: _____

Please print

Phone: (_____) _____ _____

Date

(Copies of this form are available at www.spmcmed.com)