



**Core Occupational Clinic**  
 610 North Jefferson Ave  
 Port Allen, LA 70767  
 Phone 225-267-6626  
 Fax 985-303-6122

# Medical Authorization Form

|                                     |   |
|-------------------------------------|---|
| <b>Company:</b> _____               |   |
| <b>Patient:</b> _____               | <b>Employee ID/SSN:</b> _____ - _____ - _____ |
| <b>Job / P.O. #:</b> _____          | <b>Service Date:</b> _____ Morning Afternoon  |
| <b>Scheduler Name:</b> _____        | <b>Scheduler Phone #:</b> _____               |
| <b>Authorizing Signature:</b> _____ |   |

**REASON FOR THIS VISIT** *Please check ALL services requested*

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Pre-Employment / Annual | <input type="checkbox"/> Follow Up        | <input type="checkbox"/> Return to Duty |
| <input type="checkbox"/> Random                  | <input type="checkbox"/> Reasonable Cause | <input type="checkbox"/> Post-Accident  |

**Physical Exam**

|                                  |   |                                      |
|----------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Non-DOT | <input type="checkbox"/> Return to Work | <input type="checkbox"/> Asbestos    |
| <input type="checkbox"/> DOT     | <input type="checkbox"/> Hazwoper       | <input type="checkbox"/> Other _____ |

**Ancillary Test**

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Audiometric Test | <input type="checkbox"/> Pulmonary Function Test | <input type="checkbox"/> Respirator Fit Test |
| <input type="checkbox"/> EKG              |  |  |

**Respirator Mask**

|  |   |   |
|--|---|---|
| <input type="checkbox"/> 3M 6000 HF    | <input type="checkbox"/> MSA Comfo Classis      | <input type="checkbox"/> Scott AV 3000      |
| <input type="checkbox"/> 3M 6800 FF    | <input type="checkbox"/> MSA ADV 200LS HF       | <input type="checkbox"/> Scott AV 2000 FF   |
| <input type="checkbox"/> North 7660    | <input type="checkbox"/> MSA ADV 4000 FF        | <input type="checkbox"/> Dust Mask          |
| <input type="checkbox"/> North 7700 HF | <input type="checkbox"/> MSA Ultravue           | <input type="checkbox"/> Drager Panorama FF |
| <input type="checkbox"/> North 7600    | <input type="checkbox"/> MSA Ultravue FF Escape | <input type="checkbox"/> Moldex 2200 N95    |

**Substance Abuse Testing**

|   |   |   |
|---|---|---|
| <p><b>Urine and Hair Drug Screen</b></p> <input type="checkbox"/> 10 Panel Non-DOT (CORE is MRO)<br><input type="checkbox"/> Collect Only Non-DOT<br><input type="checkbox"/> DISA Non-DOT Collection<br><input type="checkbox"/> Hair Collect (CORE is MRO)<br><input type="checkbox"/> Hair Collect Only<br><input type="checkbox"/> DISA Hair Collection | <p><b>Instant Drug Screen</b></p> <input type="checkbox"/> 10 Panel Instant<br><input type="checkbox"/> Other _____ | <p><b>Breath Alcohol Testing</b></p> <input type="checkbox"/> Breath Alcohol Test Non-DOT<br><input type="checkbox"/> DISA Breath Alcohol DOT<br><input type="checkbox"/> Other _____ |
|---|---|---|

**Laboratory Test**

|                              |   |   |
|------------------------------|---|---|
| <input type="checkbox"/> CBC | <input type="checkbox"/> Industrial Chemistry | <input type="checkbox"/> Lead & ZPP Combo |
|------------------------------|---|---|

**X-Rays**

|  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Chest 1 View        | <input type="checkbox"/> Chest 2 View | <input type="checkbox"/> B-Reader 1 CXR View |
| <input type="checkbox"/> B-Reader 2 CXR View | <input type="checkbox"/> L-Spine      |  |

**Injections/Vaccinations**

|  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Flu Vaccination | <input type="checkbox"/> Tetanus Shot | <input type="checkbox"/> Hepatitis B Series |
| <input type="checkbox"/> TB Skin Test    |                                       |   |

**Injury Treatment**

|                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> New Injury | <input type="checkbox"/> Follow-up Visit |
|-------------------------------------|--|

**Other Services**