The DOCTORS Center
Urgent Care.

AUTHORIZATION FOR EXAMINATION OR TREATMENT

Patient Name: _____ SS#: _____

Employer: Flour Bluff ISD Date of Birth: _____

Work Related
_____ Injury _____ Illness

Date of Injury _____

Substance Abuse Testing (Check all that apply)
_____ Regulated drug screen
_____ Non-regulated drug screen
_____ Triage 5 Panel (Instant)
_____ Triage 10 Panel (Instant)
_____ Collection only
_____ Breath alcohol
_____ Other _____

Type of Substance Abuse Testing
_____ Pre-placement
_____ Reasonable cause
_____ Post-accident
_____ Random
_____ Periodic
_____ Follow up

Physical Examination
_____ Pre-placement _____ Annual

DOT Physical Examination
_____ Pre-placement
_____ Recertification

Special Examination
_____ Asbestos
_____ Respirator fit test
_____ Half Mask _____ Full Mask
_____ Audiogram
_____ HPE
_____ Pulmonary function test
_____ Other _____

Billing (Check if applicable)
_____ Employee to pay
_____ Bill employer
_____ Bill Workman's Comp Carrier

Special Instructions/Comments: _____

_____

Authorized By: Kimberly Howard Digitally signed by Kimberly Howard DN: cn=Kimberly Howard, o=FBISD, ou, email=khoward@flourbluffschools.net, c=US Date: 2019.02.26 07:52:09 -06'00' Kim Howard
Signature Print

Phone: (_____) _____ _____
Date

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