Occupational Health

OCCUPATIONAL HEALTH SERVICES
Authorization For Treatment and Billing

EFFFECTIVE 7-31-2017

❑ Bruce Twp.	❑ Chesterfield	❑ Fraser	❑ Shelby Twp.	❑ Harbor Town	❑ Brownstown
810-798-6411	586-421-3052	586-285-3870	586-323-4700	313-656-1618	734-287-1412
Fax: 810-798-6419	Fax: 586-421-3061	Fax: 586-285-3814	Fax: 586-323-4710	Fax: 313-565-1612	Fax: 734-287-1413

COMPANY INFORMATION

Company name:

Address:	City:	State:	Zip code:

Phone number: ( )	Fax number: ( )	Designated Employer Representative:

Workers Compensation Carrier:	Phone number: ( )

Address:	City:	State:	Zip code:

Authorized by:	Title:	Verbal authorization had to be obtained: ❑ Yes By: Date/Time:

EMPLOYEE INFORMATION

Name:	Date of birth:	Job Title:

SERVICES REQUESTED *See Letter Of Understanding for complete list of company protocols*

Reason for testing
- ❑ Pre-Employment
- ❑ Reasonable suspicion
- ❑ Recertification
- ❑ Annual
- ❑ Fit for Duty
- ❑ Follow – up
- ❑ Random
- ❑ Post-accident
- ❑ Other ______________________

❑ **Work injury** ****please indicate if post-accident testing is required*****
Brief description of injury:

____
____
____

Physical Examinations
- ❑ DOT
- ❑ Basic Physical
- ❑ Other ________________

Drug Testing & BAT
- ❑ 5 Panel
- ❑ 10 Panel
- ❑ DOT
- ❑ Instant
- ❑ Hair - collection
- ❑ BAT
- ❑ Other:__________

Breath Alcohol Testing
- ❑ DOT Federal Breath Alcohol Test
- ❑ Non-DOT Breath Alcohol Test

Other
- ❑ TB testing
- ❑ Audiogram
- ❑ Immunization
- ❑ Titer Type____________________
- ❑ Pulmonary Function Test
- ❑ X-ray, single view
- ❑ Other: ______________________

CONSENT TO TREAT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby give consent to Henry Ford Health System Occupational Health Services and the attending physician for examination and treatment. I also authorize release of information pertaining to this specific treatment, physical examination and testing to my employer or entity that ordered and authorized these tests.

Employee / Client Signature	Date:

CONSENT FOR DRUG AND ALCOHOL TESTING AND AUTHORIZATION TO RELEASE INFORMATION

In the event that I am subject to the following drug and alcohol testing, I hereby give my consent to Henry Ford Health System Occupational Health Services to take samples and further give consent to the same facility to forward the sample to the laboratory to perform drug testing on such samples. I further give my permission to release the result of such test(s) to Henry Ford Health System Occupational Health Services and authorized company management.

Employee/Client Signature______________________________ Date: ______________
Witness Signature: Date:

THIS SECTION FOR HFHS STAFF ONLY

DIAGNOSIS / TREATMENT RECOMMENDATION

May return to regular work with / without restriction
Date: ______________
Restrictions:
____
Resume regular work on ______________(date)

As much as Splint/Bandage permits
No work: Estimated date of return (date) ______________
Other (explain)
____

Results of Pre-Employment Exam Approved NOT Approved, reason______________	Approved conditionally, reason:______________
DISPOSITION Return to work (date) __________ Sent home (date) __________	Return to clinic on (date) __________ Discharge to Company (date) __________

Signature of Provider______________________________ **Time of discharge** ______________

Company Contacted (yes/signature) phone / fax ______________ **(left message/signature)** ______________