Henry Ford Health System
Occupational Health

OCCUPATIONAL HEALTH SERVICES
Authorization For Treatment and Billing

❑ Bruce Twp	❑ Chesterfield	❑ Fraser	❑ Shelby Twp.	❑ Harbor Town	❑ Woodhaven
810-798-6411	586-421-3052	586-285-3850	586-323-4719	313-656-1618	734-671-2870
Fax: 810-798-6501	Fax: 586-421-3061	Fax: 586-285-3814	Fax: 586-323-4710	Fax: 313-656-1612	Fax: 734-671-2860

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) _____