PRIME
OCCUPATIONAL MEDICINE

Medical Authorization Form

All Authorizations MUST be completed in its entirety before being seen at a PRIME facility.

• 3515 LA Hwy 1 Port Allen, LA 70767 portallen@primeoccmed.com	• 15475 Airline Hwy Baton Rouge, LA 70817 batonrouge@primeoccmed.com	• 3584 W. Airline Hwy Reserve, LA 70084 reserve@primeoccmed.com	• 303 W. Judge Perez Dr. Chalmette, LA 70043 Chalmette@primeoccmed.com	• 3820 FM 365 Suite 100 Port Arthur, TX 77642 portarthur@primeoccmed.com
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THE BELOW INFOMATION IS REQUIRED: **TODAY'S DATE: _____**

Employer Name:		**Phone Number:**	
Company ID:		**Employer Address:**	
City & State:		**Job Number:**	
PO Number:		**Branch/Region:**	

Employee Name: _____ **SSN:** _____ **Job Title:** _____ **Date of Service:** _____

☐ **Injury Initial Visit: Type and Date of Injury:** _____

☐ **Injury Visit (Follow-up Visit): Type and Date of Injury:** _____

PRIME Breath Alcohol & Drug Screen Types:

Reason for Visit:
- ☐ Pre-Placement
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion/Cause
- ☐ Return to Duty
- ☐ Follow-up
- ☐ Other: _____

Breath Alcohol:
- ☐ DOT
- ☐ NON-DOT

Quick Screen (Urine):
- ☐ 5 Panel
- ☐ 10 Panel
- ☐ 12 Panel
- ☐ T-Square

Non-DOT (Urine):
- ☐ 5 Panel (046)
- ☐ 10 Panel (259)
- ☐ 12 Panel (605)
- ☐ Synthetic Marijuana (2912)
- ☐ Synthetic Opioid (922)
- ☐ Other Panel: _____

DOT (Urine):
- ☐ FMSCA
- ☐ PHMSA
- ☐ USCG
- ☐ FRA
- ☐ FAA
- ☐ FTA

PRIME Hair Test (5 Panel): ☐ **YES** ☐ **NO**

Drug Screen Observation:
- ☐ Direct Observation
- ☐ Indirect Observation
- ☐ Monitored Observation

Reason for Visit:
- ☐ Pre-Placement
- ☐ Annual
- ☐ Fit For Duty
- ☐ Return to Work
- ☐ Follow-up
- ☐ Other: _____

Physical Exam:
- ☐ DOT
- ☐ Hazmat
- ☐ Non-DOT
- ☐ Operator
- ☐ Asbestos
- ☐ Offshore
- ☐ Coast Guard
- ☐ Silica
- ☐ Benzene
- ☐ Return to Work Clearance
- ☐ Fit for Duty Clearance
- ☐ Other: _____

Functional Exam:
- ☐ Level 1 (PRIME)
- ☐ Level 2 **Employer Specific**

Job Description must be received by the clinic

☐ Other: _____

Audiogram:
- ☐ Baseline
- ☐ Annual
- ☐ Add STS Comparison
- ☐ Retest
- ☐ Add Consultation if needed

Vision:
- ☐ Titmus
- ☐ Jaeger
- ☐ Snellen
- ☐ Ishihara

☐ **Pulmonary Function Test**

Respirator FIT Test:

☐ Qualitative ☐ Quantitative

Mask #1: _____

Mask #2: _____

Mask #3: _____

Mask #4: _____

Stress Test: (Referred Out)
- ☐ Cardiac
- ☐ Treadmill

Laboratory Test:
- ☐ CBC
- ☐ BMP
- ☐ TSH
- ☐ TB Gold
- ☐ T-Spot
- ☐ HgA1c **(Instant)**
- ☐ HgA1c **(send to lab)**
- ☐ CMP
- ☐ LIPID

Other_____

TB Skin Test: ☐ **YES** ☐ **NO**

Employee must be able to return to clinic within 48-72hrs. to have test read.

X-Ray:
- ☐ Chest 1 View
- ☐ Chest 2 View
- ☐ X-Ray Lumbar Spine
  - ☐ 2 – 3 views ☐ 4 – 5 Views
- ☐ X-Ray C-Spine

Other: _____

☐ **B-read - Special Type of Reading** ***(this is not an x-ray)***

☐ **MRI Lumbar Spine w/o Contrast**

☐ **EKG**

TPA Reason for Visit:
- ☐ Pre-Placement
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion/Cause
- ☐ Return to Duty
- ☐ Follow-up
- ☐ Other: _____

TPA Services:
- ☐ Physical Exam
- ☐ Hair
- ☐ Oral Fluid
- ☐ eScreen Collection
- ☐ Noble Collection (urine)
- ☐ BAT (NON-DOT)
- ☐ BAT (DOT)
- ☐ Urine (NON-DOT)
- ☐ Urine (DOT)
- ☐ USCG
- ☐ FMCSA
- ☐ PHMSA
- ☐ FRA
- ☐ FAA
- ☐ FTA
- ☐ NASAP/ASAP
- ☐ Pipeline Consortium

DISA Account Number:

_____

DISA Policy:
- ☐ DCCHA
- ☐ DCCHT
- ☐ DCCHT/Randoms
- ☐ DCOF
- ☐ DCEO
- ☐ DCC

Other TPA Name / Account Number:

_____

Other Services: _____

***Send** the form with your employee or **email** to the designated clinic above.*

EMPLOYER: This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below.

Employer Signature (REQUIRED)	Printed Name (REQUIRED)	Title	Date