

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

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THE BELOW INFORMATION 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: _____

<p>PRIME Breath Alcohol & Drug Screen Types: Reason for Visit:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Pre-Placement - <input type="checkbox"/> Random - <input type="checkbox"/> Post-Accident - <input type="checkbox"/> Reasonable Suspicion/Cause - <input type="checkbox"/> Return to Duty - <input type="checkbox"/> Follow-up - <input type="checkbox"/> Other: _____ <p>Breath Alcohol:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> DOT - <input type="checkbox"/> NON-DOT <p>Quick Screen (Urine):</p> <ul style="list-style-type: none"> - <input type="checkbox"/> 5 Panel - <input type="checkbox"/> 10 Panel - <input type="checkbox"/> 12 Panel - <input type="checkbox"/> T-Square <p>Non-DOT (Urine):</p> <ul style="list-style-type: none"> - <input type="checkbox"/> 5 Panel (046) - <input type="checkbox"/> 10 Panel (259) - <input type="checkbox"/> 12 Panel (605) - <input type="checkbox"/> Synthetic Marijuana (2912) - <input type="checkbox"/> Synthetic Opioid (922) - <input type="checkbox"/> Other Panel: _____ <p>DOT (Urine):</p> <ul style="list-style-type: none"> - <input type="checkbox"/> FMSCA - <input type="checkbox"/> PHMSA - <input type="checkbox"/> USCG - <input type="checkbox"/> FRA - <input type="checkbox"/> FAA - <input type="checkbox"/> FTA <p>PRIME Hair Test (5 Panel): <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Drug Screen Observation:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Direct Observation - <input type="checkbox"/> Monitored Observation 	<p>Reason for Visit:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Pre-Placement - <input type="checkbox"/> Annual - <input type="checkbox"/> Fit For Duty - <input type="checkbox"/> Return to Work - <input type="checkbox"/> Follow-up - <input type="checkbox"/> Other: _____ <p>Physical Exam:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> DOT - <input type="checkbox"/> Hazmat - <input type="checkbox"/> Non-DOT - <input type="checkbox"/> Operator - <input type="checkbox"/> Asbestos - <input type="checkbox"/> Offshore - <input type="checkbox"/> Coast Guard - <input type="checkbox"/> Silica - <input type="checkbox"/> Benzene - <input type="checkbox"/> Return to Work Clearance - <input type="checkbox"/> Fit for Duty Clearance - <input type="checkbox"/> Other: _____ <p>Functional Exam:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Level 1 (PRIME) - <input type="checkbox"/> Level 2 Employer Specific <p><i>Job Description must be received by the clinic</i></p> <p><input type="checkbox"/> Other: _____</p> <p>Audiogram:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Baseline - <input type="checkbox"/> Annual - <input type="checkbox"/> Add STS Comparison - <input type="checkbox"/> Retest - <input type="checkbox"/> Add Consultation if needed <p>Vision:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Titmus - <input type="checkbox"/> Jaeger - <input type="checkbox"/> Snellen - <input type="checkbox"/> Ishihara 	<p><input type="checkbox"/> Pulmonary Function Test</p> <p>Respirator FIT Test:</p> <p><input type="checkbox"/> Qualitative <input type="checkbox"/> Quantitative</p> <p>Mask #1: _____</p> <p>Mask #2: _____</p> <p>Mask #3: _____</p> <p>Mask #4: _____</p> <p>Stress Test: (Referred Out)</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Cardiac - <input type="checkbox"/> Treadmill <p>Laboratory Test:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> CBC - <input type="checkbox"/> BMP - <input type="checkbox"/> TSH - <input type="checkbox"/> TB Gold - <input type="checkbox"/> T-Spot - <input type="checkbox"/> HgA1c (Instant) - <input type="checkbox"/> HgA1c (send to lab) - <input type="checkbox"/> CMP - <input type="checkbox"/> LIPID <p>Other: _____</p> <p>TB Skin Test: <input type="checkbox"/> YES <input type="checkbox"/> NO <i>Employee must be able to return to clinic within 48-72hrs. to have test read.</i></p> <p>X-Ray:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Chest 1 View - <input type="checkbox"/> Chest 2 View - <input type="checkbox"/> X-Ray Lumbar Spine - <input type="checkbox"/> 2 - 3 views <input type="checkbox"/> 4 - 5 Views - <input type="checkbox"/> X-Ray C-Spine - Other: _____ <p><input type="checkbox"/> B-read - Special Type of Reading (this is not an x-ray)</p> <p><input type="checkbox"/> MRI Lumbar Spine w/o Contrast</p> <p><input type="checkbox"/> EKG</p>	<p>TPA Reason for Visit:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Pre-Placement - <input type="checkbox"/> Random - <input type="checkbox"/> Post-Accident - <input type="checkbox"/> Reasonable Suspicion/Cause - <input type="checkbox"/> Return to Duty - <input type="checkbox"/> Follow-up - <input type="checkbox"/> Other: _____ <p>TPA Services:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> Physical Exam - <input type="checkbox"/> Hair - <input type="checkbox"/> Oral Fluid - <input type="checkbox"/> eScreen Collection - <input type="checkbox"/> Noble Collection (urine) - <input type="checkbox"/> BAT (NON-DOT) - <input type="checkbox"/> BAT (DOT) - <input type="checkbox"/> Urine (NON-DOT) - <input type="checkbox"/> Urine (DOT) - <input type="checkbox"/> USCG - <input type="checkbox"/> FMCSA - <input type="checkbox"/> PHMSA - <input type="checkbox"/> FRA - <input type="checkbox"/> FAA - <input type="checkbox"/> FTA - <input type="checkbox"/> NASAP/ASAP - <input type="checkbox"/> Pipeline Consortium <p>DISA Account Number: _____</p> <p>DISA Policy:</p> <ul style="list-style-type: none"> - <input type="checkbox"/> DCCHA - <input type="checkbox"/> DCCHT - <input type="checkbox"/> DCCHT/Randoms - <input type="checkbox"/> DCOF - <input type="checkbox"/> DCEO - <input type="checkbox"/> DCC <p>Other TPA Name / Account Number: _____</p>
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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
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