Decatur Morgan
Occupational Medicine

Decatur Morgan Hospital

Treatment Authorization

Patient's Name: _____ Date: _____

Company: _____ Phone: _____

Authorized for treatment by: _____ Print Name: _____

☐ Worker's Compensation Injury

Include: ☐ Drug Screen ☐ EBT (Evidential Breath Test)

DRUG SCREENS MUST BE AT THE CLINIC NO LATER THAN 4:00 PM

☐ Pre-Employment Drug Screen

☐ Rapid: 5 _____ 10 _____
☐ Federal DOT ☐ Non-Federal 5 _____ 10 _____

☐ Federal/Non-Federal Drug Screening (select test and reason)

Test:

☐ Federal DOT ☐ Non-Federal 5 _____ 10 _____
☐ Hair Test

Reason:

☐ For cause drug screen
☐ Random drug screen
☐ Follow-up drug screen
☐ Return to duty drug screen
☐ Post-accident drug screen

☐ EBT (Evidential Breath Test) ☐ Federal ☐ Non-Federal

☐ Pre-employment physical
☐ DOT physical
☐ Annual physical
☐ Respirator physical
Include: ☐ Pulmonary Function Test (PFT)
☐ Respirator review and clearance
Include: ☐ Pulmonary Function Test (PFT)
☐ Return to duty physical
☐ Fit for duty physical
☐ TB skin test
☐ Respirator fit test
☐ Audiogram
☐ Other _____

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Fax - 256.973.4329
Monday - Thursday : 7:30 AM - 5:30 PM
Friday : 8:00 AM - 5:00 PM