Treatment Authorization Form

Date of Authorization: _____

Employee Name: _____ Company Name: _____

Authorizing Person's Signature: _____ Contact Phone Number: _____

*******By signing this form, I authorize AllSouth Urgent Care to bill the above company for the following services.*******

Urine Drug Screening

- ☐ Collection and Test
- ☐ Collection Only (Company Lab Acct)
- ☐ Instant
- ☐ Lab Based
- ☐ 5 Panel ☐ 10 Panel
- ☐ Non-DOT ☐ DOT
- ☐ Post-Accident
- ☐ Pre-Employment
- ☐ Random
- ☐ Follow-Up
- ☐ Return to Duty
- ☐ Other _____
- ☐ Observed (Additional Charge)

Hair Drug Screening

- ☐ Collection and Test (5 Panel)
- ☐ Collection Only (Company Lab Acct)
- ☐ Post-Accident
- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Other _____

TB Screening

- ☐ TB Skin Test
- ☐ TB Gold QuantiFERON
- ☐ 1 View Chest X-ray

Physical

- ☐ DOT (FMSCA FORM)
- ☐ Non-DOT
- ☐ Pre-Employment/New
- ☐ Annual/Re-Certification
- ☐ Company Form Required

Vaccines

- ☐ Hepatitis B
- ☐ TDAP
- ☐ TD (Tetanus and Diphtheria)
- ☐ Influenza

Titers/Labs

- ☐ Hepatitis B Titer
- ☐ MMR Titer
- ☐ Varicella Titer
- ☐ Other _____

Breath Alcohol Testing

- ☐ DOT
- ☐ Non-DOT
- ☐ Post-Accident
- ☐ Pre-Employment
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Other _____

Other Services

- ☐ EKG
- ☐ Pulmonary Function (East ONLY)
- ☐ Respirator Fit Test (Mask Required)
- ☐ Audiogram
- ☐ Vision Test (Snellen Chart)
- ☐ Other _____

Work Comp Accident

Date of Injury: _____

Injury Type: _____

Post-Accident UDS ☐YES ☐NO

Post-Accident BAT ☐YES ☐NO

Bill To: ☐Carrier ☐Company

Special Instructions: _____

Please send the completed authorization form to **nurse@aucdothan.com** or by fax. Verbal authorizations will not be accepted.

☐East Location
1052 Ross Clark Circle
Dothan, AL 36303
P 334-699-3600 F 334-699-3601
Hours: Monday-Friday 8am-6pm

☐Pavilion Location
4585 Montgomery Hwy
Dothan, AL 36303
P 334-340-2600 F 334-340-2620
Hours: Monday-Friday 8am-6pm
Saturday 8am-2pm