HILLCREST MEDICAL CLINIC

511 E. Manchester Blvd. Inglewood, CA 90301
Tel: (310) 672-9000 Fax: (310) 672-9030

Authorization for Medical Services

Date: _____
Person to be treated: _____
Company: _____
Address: _____
Phone: _____ Email: _____
Insurance Company: _____
Authorization by: _____
(sign and print name & title)

INJURY/ ILLNESS TREATMENT

- ☐ Work Injury Treatment
- ☐ Illness – Bill Employer
- ☐ Illness – Bill Patient
- ☐ Other: _____
- ☐ Date of Injury_____ Describe Injury: _____

_____

_____

-Additional Services to Include:

- ☐ Include – DOT Drug Test
- ☐ Include – Non- DOT Drug Test
- ☐ Include – Breath Alcohol Test

PHYSCIAL EXAMS

- ☐ Pre – Employment Physical
- ☐ Fit for Duty/ Return to Work
- ☐ DMV/ DOT Physical
- ☐ Other : _____

-Annual Testing:

- ☐ TB Testing
- ☐ Audio/ Hearing Test
- ☐ Vision Test
- ☐ Other: _____

SUBSTANCE ABUSE TESTING

- ☐ Follow- up
- ☐ Post-Accident
- ☐ Return to Duty
- ☐ Pre- Placement
- ☐ Random
- ☐ Reasonable Suspicion

-Type of Test to be performed

- ☐ DOT Urine Drug Screen
- ☐ Breath Alcohol (BAT)
- ☐ Hair Collection Drug Screen
- ☐ Non DOT Drug Screen