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EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

PATIENT NAME: _____ **SSN/ ID#:** _____

COMPANY NAME: _____ **DATE OF BIRTH:** _____

REASON FOR TEST

☐ Pre-employment ☐ Post Accident

☐ Random ☐ Follow-up

☐ Reasonable Suspicion ☐ Return to Duty

SUBSTANCE ABUSE TESTING

☐ DOT Drug Screen ☐ 10 Panel/ Rapid Screen

☐ Non-DOT Drug Screen ☐ 5 Panel/ Rapid Screen

☐ Hair Drug Test

PHYSICAL EXAMINATIONS

☐ DOT Physical (Does not include DOT drug screen)

☐ Pre- placement Physical (Does not include drug screen)

☐ Respirator Physical ☐ Return to work

☐ Audiogram with exam ☐ Medical Surveillances Exam

☐ Immigration Exam ☐ Fit for Duty

☐ Pulmonary Function Test

☐ Other: _____

BILLING

☐ Bill company for services

☐ Employee to pay at time of service

☐ Bill Workers' Compensation Carrier

Carrier: _____

Address: _____

Phone #: _____

Claim#: _____

Authorized By: _____

Signature: _____

Title: _____

Date:_____

Contact Phone: _____

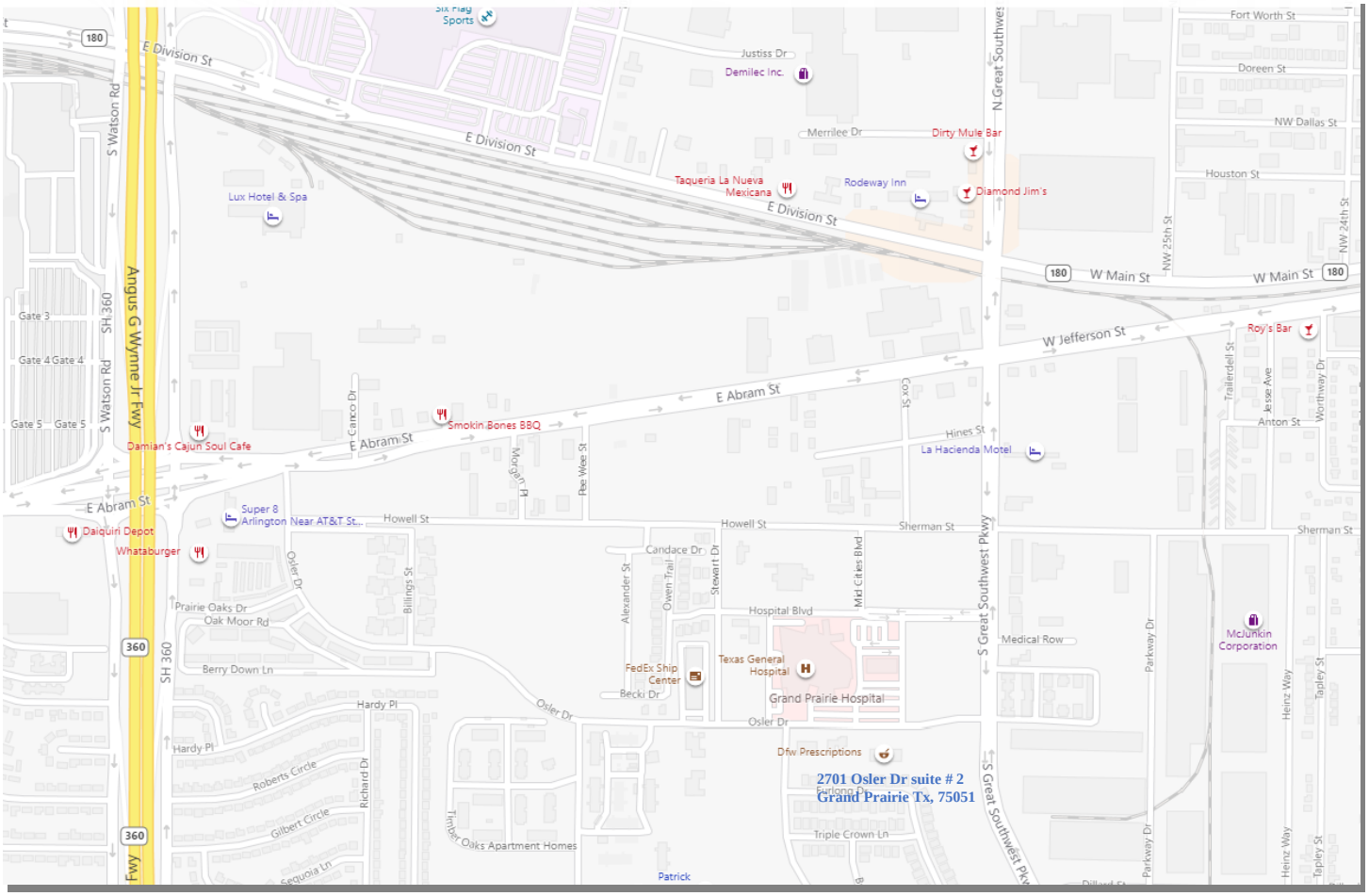
Company Fax: _____

Company Email: _____

EXPLAIN HOW THE INJURY OCCURRED

***DATE OF INJURY_____/_____/_____

E-FAX IN ADVANCE TO 833-628-6624
OR SEND WITH EMPLOYEE



LYRAD HEALTH

OFFICE HOURS
Monday-Friday 9:00 AM – 4:00 PM

Walk-ins Welcome ● No Appointment Necessary ● Minimal Wait Times

2701 Osler Drive Suite #2 ● Grand Prairie, TX ● 75051 ● Office: 972-639-3992