



CareFirst MEDICAL GROUP

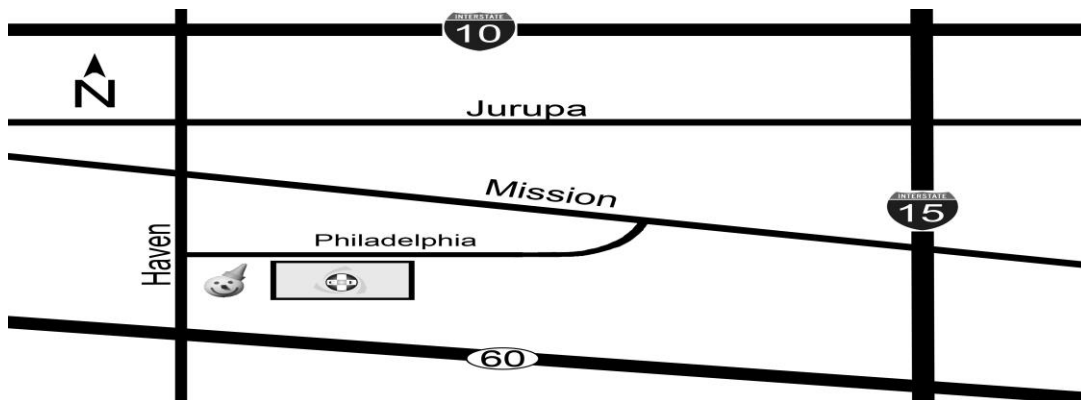
3550 E. Philadelphia Street, Suite 150, Ontario, CA 91761 • Phone (909) 773-0022 • Fax (909) 781-6015

TREATMENT AUTHORIZATION FORM

Patient Name:	Employer Name:
Date:	Authorized By / Title:
Time:	Employer Telephone:
Work Comp. Insurance:	FOR CFMG USE ONLY: <input type="checkbox"/> VERBAL AUTHORIZATION

TREATMENT OF INJURY	
Date of Injury: _____ Time of Injury: _____ Injured Body Part: _____ <input type="checkbox"/> PHYSICIAN TO DETERMINE IF ALLEGED INJURY IS WORK RELATED?	
PHYSICAL EXAM	
<input type="checkbox"/> DMV/DOT PHYSICAL <input type="checkbox"/> PRE OR POST EMPLOYMENT PHYSICAL <input type="checkbox"/> RETURN TO WORK or FIT FOR DUTY	<input type="checkbox"/> BACK EVALUATION <input type="checkbox"/> SPIROMETRY or RESPIRATORY FIT TEST <input type="checkbox"/> OTHER: _____
DRUG SCREEN / ALCOHOL TESTING (PICTURE ID REQUIRED)	
<input type="checkbox"/> PRE / POST OFFER EMPLOYMENT <input type="checkbox"/> RANDOM	<input type="checkbox"/> POST ACCIDENT <input type="checkbox"/> REASONABLE SUSPICION
<input type="checkbox"/> DRUG TEST <input type="checkbox"/> RAPID _____ PANEL <input type="checkbox"/> DOT <input type="checkbox"/> NON-DOT	<input type="checkbox"/> BREATH ALCOHOL TEST <input type="checkbox"/> DOT (BAT) <input type="checkbox"/> NON-DOT (BAT)
	<input type="checkbox"/> HAIR <input type="checkbox"/> DOT <input type="checkbox"/> NON-DOT <input type="checkbox"/> OTHER: _____

CLINIC HOURS Monday through Friday - 8am through 7pm Saturday/Sunday/Holidays - CLOSED	FOR QUESTIONS PLEASE CALL (909) 773-0022
---	---



"Focusing on your care first."