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: ☐ VERBAL AUTHORIZATION

TREATMENT OF INJURY

Date of Injury: _____ Time of Injury: _____

Injured Body Part: _____

☐ PHYSICIAN TO DETERMINE IF ALLEGED INJURY IS WORK RELATED?

PHYSICAL EXAM

☐ DMV/DOT PHYSICAL	☐ BACK EVALUATION
☐ PRE OR POST EMPLOYMENT PHYSICAL	☐ SPIROMETRY or RESPIRATORY FIT TEST
☐ RETURN TO WORK or FIT FOR DUTY	☐ OTHER: _____

DRUG SCREEN / ALCOHOL TESTING (PICTURE ID REQUIRED)

☐ PRE / POST OFFER EMPLOYMENT	☐ POST ACCIDENT
☐ RANDOM	☐ REASONABLE SUSPICION

☐ DRUG TEST ☐ RAPID _____ PANEL ☐ DOT ☐ NON-DOT	☐ BREATH ALCOHOL TEST ☐ DOT (BAT) ☐ NON-DOT (BAT)	☐ HAIR ☐ DOT ☐ NON-DOT ☐ OTHER: _____

CLINIC HOURS
Monday through Friday - 8am through 7pm
Saturday/Sunday/Holidays - CLOSED

FOR QUESTIONS PLEASE CALL
(909) 773-0022