

Northwest Health – Occupational Medicine

Authorization Form

LA PORTE

311 Boyd Blvd.
La Porte, IN 46350
219-326-2664
Fax 219-326-2653
8 a.m. – 4:30 p.m.
NWHOccMedregLP@NWHealthin.com

VALPARAISO

1251 Eastport Centre Drive
Valparaiso, IN 46383
219-462-9205
Fax 219-462-9526
8 a.m. – 4:30 p.m.
NWHOccMedregValpo@NWHealthin.com

NOTE

If after hours, NW Health – Occupational Medicine works closely with the urgent cares and emergency rooms for both the Porter and La Porte Hospital systems; and in many cases they are familiar with your company and your protocols. If one of those facilities is convenient, we encourage you to use them for your after hour injury care. Otherwise, use your local urgent care or emergency room. All follow-up care can be provided at one of our convenient occupational medicine clinics.

Company _____ Date _____

Employee/Applicant _____ Job Title _____

Visit Authorized by (PRINT) _____ Job Title _____

Phone _____ Fax _____

Authorized Signature _____

By my signature above, I authorize NW Health – Occupational Medicine to see the above employee/applicant. If this is a work-related injury visit, I am authorizing NW Health – Occupational Medicine to diagnose and treat this individual with such medical and surgical services as may be necessary to provide proper care subject to the provision of Indiana law.

PURPOSE FOR VISIT (Select one only)

- | | | |
|--|---|---|
| <input type="checkbox"/> Pre-employment/post-offer | <input type="checkbox"/> Random | <input type="checkbox"/> Follow-up/surveillance |
| <input type="checkbox"/> Post-accident/injury | <input type="checkbox"/> Reasonable cause | <input type="checkbox"/> Annual/periodic |

SERVICE(S) REQUESTED (Select all that apply. *Picture ID required for all drug/alcohol tests)

- Treatment of New Injury (Date of Injury: ____/____/____; Nature of Injury: _____)
- | | | |
|--|---|--|
| <input type="checkbox"/> DOT Drug Screen* | <input type="checkbox"/> Physical | <input type="checkbox"/> Respirator Clearance |
| <input type="checkbox"/> Non-DOT Drug Screen* | <input type="checkbox"/> DOT/CDL Physical | <input type="checkbox"/> Pulmonary Function/Spirometry |
| <input type="checkbox"/> Drug Screen, collection only* | <input type="checkbox"/> Return-to-Work Physical | <input type="checkbox"/> Audiogram |
| <input type="checkbox"/> Breath Alcohol – DOT* | <input type="checkbox"/> Fitness-for-Duty Evaluation | <input type="checkbox"/> PPD (TB test) |
| <input type="checkbox"/> Breath Alcohol – Non-DOT* | <input type="checkbox"/> Essential Function Screening | <input type="checkbox"/> Other: _____ |

If your company does not have a protocol on file, please indicate if drug and alcohol testing is required.

Special instructions: _____

REMINDER: PLEASE FOLLOW UP WITH NW HEALTH OCC MED IF ER OR URGENT CARE IS USED.