

Dr. Roxanne Dietzler, PC
 732 Thimble Shoals Blvd. Suite 102
 Newport News, Virginia 23606
 Phone 757-599-3623 & Fax 757-599-1819
www.drdietzler.com

(Form can be downloaded from website)

AUTHORIZATION TO PROVIDE MEDICAL SERVICES

Employee Name		Employee SS#:
Company Name		
Company Address		Billing Address If Different:
	<input type="checkbox"/> Check if on file	<input type="checkbox"/> Check if on file
	Company Phone:	Company Fax:

SERVICES REQUESTED: MUST HAVE A PHOTO ID AT TIME OF SERVICES

PHYSICAL EXAM

<input type="checkbox"/> Annual	<input type="checkbox"/> Asbestos	<input type="checkbox"/> Crane/Fork Lift	<input type="checkbox"/> DOT
<input type="checkbox"/> Fit for Duty	<input type="checkbox"/> FMLA	<input type="checkbox"/> Hazmat	<input type="checkbox"/> Lead
<input type="checkbox"/> Post Exposure	<input type="checkbox"/> Pre Placement	<input type="checkbox"/> Respirator	<input type="checkbox"/> Second Opinion

OTHER PHYSICAL:

SCREENING SERVICES

<input type="checkbox"/> Hearing Booth	<input type="checkbox"/> Baseline	<input type="checkbox"/> Annual	<input type="checkbox"/> Retest
<input type="checkbox"/> PFT /Questionnaire	<input type="checkbox"/> PFT / Questionnaire /Exam	<input type="checkbox"/> EKG	<input type="checkbox"/> CXR
<input type="checkbox"/> Titmus Far/Near	<input type="checkbox"/> Amsler Grid	<input type="checkbox"/> Peripheral Vision	<input type="checkbox"/> Phoria
<input type="checkbox"/> Labs (List Below)	<input type="checkbox"/> Vaccines (List Below)	<input type="checkbox"/> PPD	<input type="checkbox"/> Other (List Below)

WORKERS COMPENSATION EVALUATION:

DATE OF INJURY:

<input type="checkbox"/> NO DRUG TEST REQUIRED WITH WORKERS COMPENSATION EVALUATION	<input type="checkbox"/> POST ACCIDENT DRUG TEST REQUIRED WITH EVALUATION – CHECK TYPE OF TEST REQUESTED BELOW
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SUBSTANCE ABUSE TESTING

<input type="checkbox"/> Pre-Placement	<input type="checkbox"/> Reasonable Suspicion	<input type="checkbox"/> Random	<input type="checkbox"/> Post Accident	<input type="checkbox"/> Follow Up
<input type="checkbox"/> NIDA 5 Panel	<input type="checkbox"/> Non NIDA 5 Panel <i>with MRO</i>	<input type="checkbox"/> Non NIDA 5 Panel – <i>No MRO</i>	<input type="checkbox"/> E-Screen	
<input type="checkbox"/> Instant 2 Panel	<input type="checkbox"/> Instant 5 Panel	<input type="checkbox"/> Other		

I acknowledge the Companies responsibility for the payment of all charges related to these requested services.

Name of Authorizing Person	Signature of Authorizing Person	Phone Number	Date