NORTHWEST
MEDICAL GROUP

Authorization for Services

Patient must present **Authorization** and **Photo ID** at the time of service.

Worker's Name: Date of Birth:

Company Name: Address:

Authorized By: Title:

Phone Number: Auth Expiration Date:

SERVICES REQUESTED

DRUG & ALCOHOL TESTING

Test Type(s)

- ☐ DOT Controlled Substance Test
- ☐ NON-DOT Controlled Substance Test
  - ☐ Instant ☐ Lab
  - Panel:
- ☐ DOT Breath Alcohol Test
- ☐ NON-DOT Breath Alcohol Test
- ☐ Other or Special Requirements:

Reason

- ☐ Pre-employment
- ☐ Random
- ☐ Post-Accident
- ☐ Reasonable Suspicion
- ☐ Return to Duty (DOT Observed)
- ☐ Other (specify):

PHYSICAL EXAMINATIONS

Exam Type

- ☐ DOT Physical Exam
- ☐ NON-DOT Physical Exam
- ☐ Respirator Certification
- ☐ Other or Special Requirements:

Reason

- ☐ Post-Offer
- ☐ Recertification
- ☐ Initial/Baseline
- ☐ Periodic/Annual
- ☐ Return to Duty

ADDITIONAL TESTING

- ☐ Audiogram
- ☐ Respirator Questionnaire
- ☐ Pulmonary Function Test
- ☐ Chester Step Test
- ☐ Other or Special Requirements:
- ☐ Vison Test
- ☐ Vison Test - Color
- ☐ Lift Test
- ☐ Respirator Fit Test

BILLING INFORMATION

Billing Contact: Phone Number:

Email:

NORTHWEST MEDICAL GROUP
938 W. 3RD AVENUE
MOSES LAKE, WA 98837

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