

Medical Authorization for Treatment

EMPLOYEE INFORMATION

Date _____ Company Name _____

Name of Employee _____ Plant Location _____

Employee Birthdate _____ Employee SSN _____

Employee Job Title _____

Reason for Visit/Services Desired – Please Check all that Apply

- | | |
|--|--|
| <input type="checkbox"/> Worker's Comp/Injury ① | <input type="checkbox"/> Urine Drug Screen (UDS) ⑥ |
| <input type="checkbox"/> Physical Exam – DOT ② | <input type="checkbox"/> UDS Post-Accident |
| <input type="checkbox"/> Physical Exam – Pre-Employment ③ | <input type="checkbox"/> UDS Random |
| <input type="checkbox"/> Breath Alcohol ④ | <input type="checkbox"/> UDS Reasonable Suspicion |
| <input type="checkbox"/> PT/OT Evaluation and Treatment ⑤ | <input type="checkbox"/> UDS Pre-Employment |
| <input type="checkbox"/> X-Ray ⑧ | <input type="checkbox"/> Hair Follicle Drug Screen ⑦ |
| <input type="checkbox"/> Other Services (vaccinations, etc.) please indicate _____ | |

Please Indicate the Location for Services (Please note that not all services are available at all locations.)

- | | |
|---|---|
| <input type="checkbox"/> Memorial Health Employer Services
695 W. 2 nd Street, Suite A1
Jasper, Indiana
812.996.5750
Services: ① ② ③ ④ ⑥ ⑦ ⑧ | <input type="checkbox"/> Memorial Orthopaedic Associates
695 W. 2 nd Street, Suite A2
Jasper, Indiana
812.996.5950
Services: ① ⑧ |
| <input type="checkbox"/> Memorial Rehabilitation Services
695 W. 2 nd Street, Suite D
Jasper, Indiana
812.996.0682
Services: ⑤ | <input type="checkbox"/> Huntingburg Urgent Care
507 E. 19 th Street
Huntingburg, Indiana
812.683.4717
Services: ① ⑧ |
| <input type="checkbox"/> Memorial Hospital Emergency Department
800 W. 9 th Street
Jasper, Indiana
812.996.2345
Services: ① ④ ⑥ ⑧ | <input type="checkbox"/> Memorial Hospital Laboratory
800 W. 9 th Street
Jasper, Indiana
812.996.2345
Services: ④ ⑥ |
| <input type="checkbox"/> Other Services or Locations Not Listed: _____

_____ | |

INJURY INFORMATION

Site and Description of Employee Illness/Injury _____

Date of Injury _____ Time of Injury _____

Claim # _____

COMPANY CONTACT INFORMATION

Contact Name Tracy Troesch Contact Phone Number 812-817-0900 option #5

Contact Fax Number 812-367-1075

Company Address 432 E 15th St

City Ferdinand State IN Zip Code 47532

I authorize the above employee to be treated for the services/injury/illness noted above and I assume responsibility for the charges incurred.

Mary Hoelzel, business mgr
Company Contact/Authorized Personnel Signature _____ Date _____

EMPLOYEE/PATIENT AUTHORIZATION TO RELEASE

I, the undersigned, hereby consent to the test(s) noted above for all visits/referrals related to the injury noted above. By signing, I hereby authorize Memorial Hospital and Health Care Center and any attending and/or consulting providers to release return to work information regarding my medical treatment for this injury to my employer and the insurance and/or worker's compensation carrier for which I have assigned benefits for my treatment and care, and to my referring and any other health care provider or facility responsible for my care, if they request it. I will not hold my company, my worker's compensation carrier, any health care provider, medical personnel, hospital, medical center, or clinic legally responsible for the release or use of the physical examination report and/or test results. I agree to accept responsibility for all charges incurred should my employer or insurance plan refuse to pay. I understand a urine or hair follicle analysis will include a test to find out if there are substances in my body that a health care provider did not prescribe and/or illegal substances in my urine or hair. I understand that if I refuse to take any or all of the test(s) noted above, or if I refuse to sign this consent form, the test(s) will not be completed. I also understand that my company will be notified of my refusal. This could result in rejection of my application for employment, rejection of temporary labor services, and/or loss of employment.

Employee/Patient Signature

Date